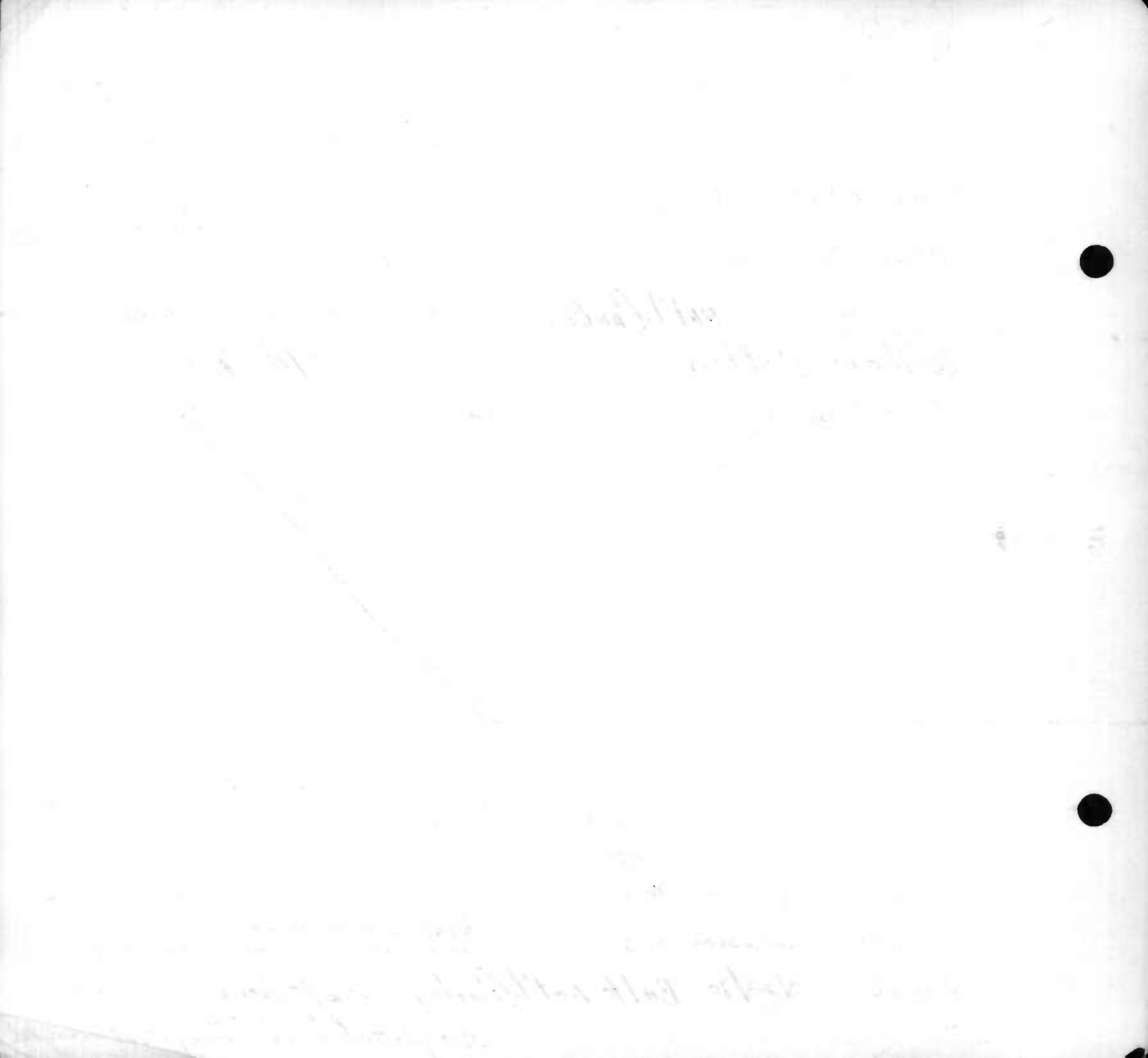


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-350		70 3001		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3001	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Button, Norman</u>				2. DATE AND HOUR OF DEATH <u>3-20-70</u> <u>5:55 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Glen Burnie</u> C. CITY OR TOWN <u>Anne Arundel</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>				E. STREET AND NUMBER <u>10009 Fitzallen Road 5200</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-90</u>		9. AGE (in years, last birthday) <u>79</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>nat'l. Conch.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Button</u>				14. MOTHER'S MAIDEN NAME <u>McCune</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes (vet)</u>				16. SOCIAL SECURITY NO. <u>097-03-2457-2</u>		17. INFORMANT <u>wife on admission</u>			
18. <u>59311</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>acute MI</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest.</u> (B) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>due to tubular necrosis.</u> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>17 March 1970</u> to <u>20 March 1970</u> that (I) (we) last saw the deceased alive on <u>20 March 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John M. Jackson, M.D.</u>				23B. DATE SIGNED <u>20 March 1970</u>				23C. PHYSICIAN'S NAME (Type) <u>JEAN M. JACKSON, M.D.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>3/23/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Sailer, M.D.</u>		25C. FUNERAL DIRECTOR <u>Singleton Funeral Home / R. B. Buevich, Md.</u>			

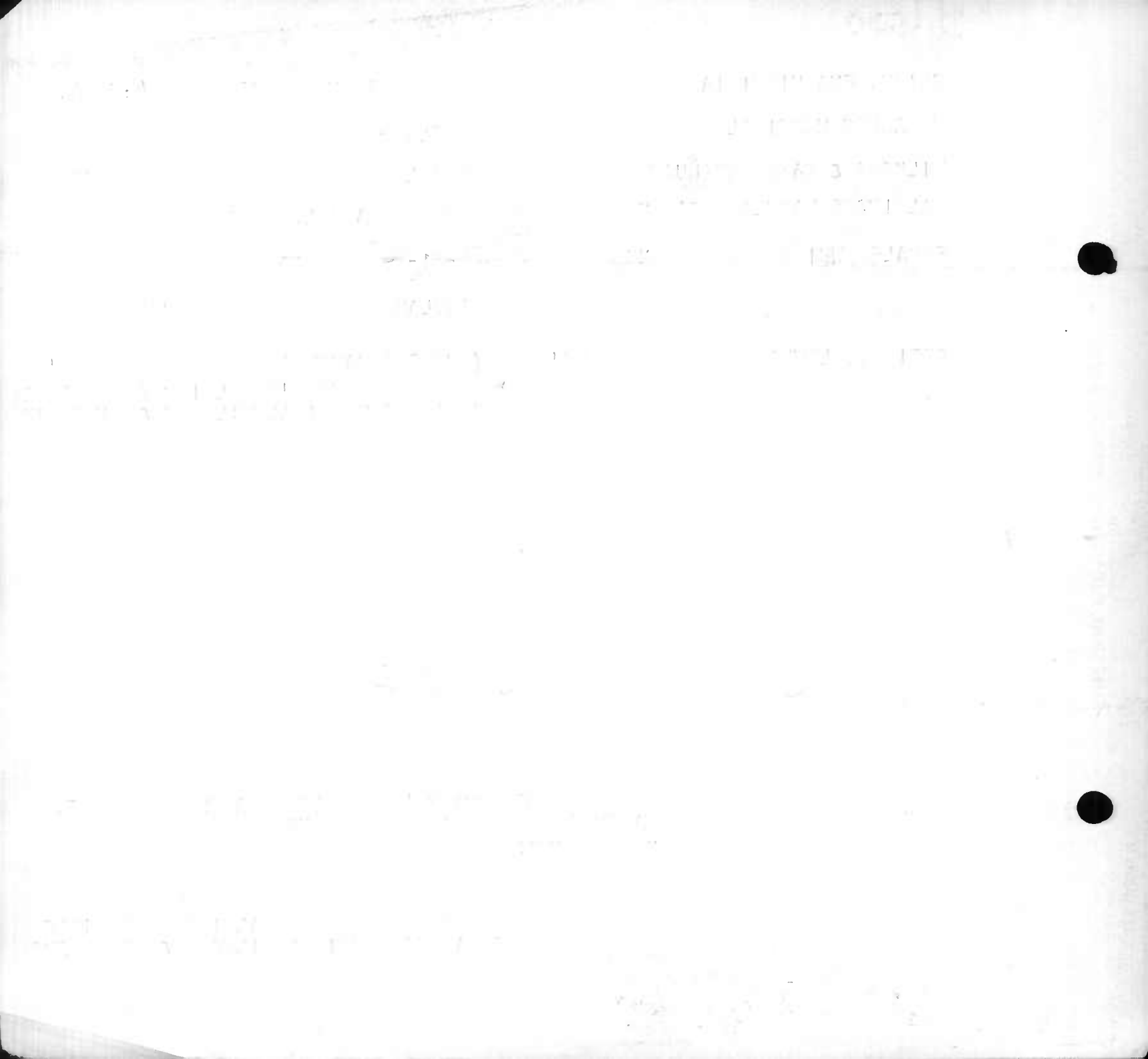




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

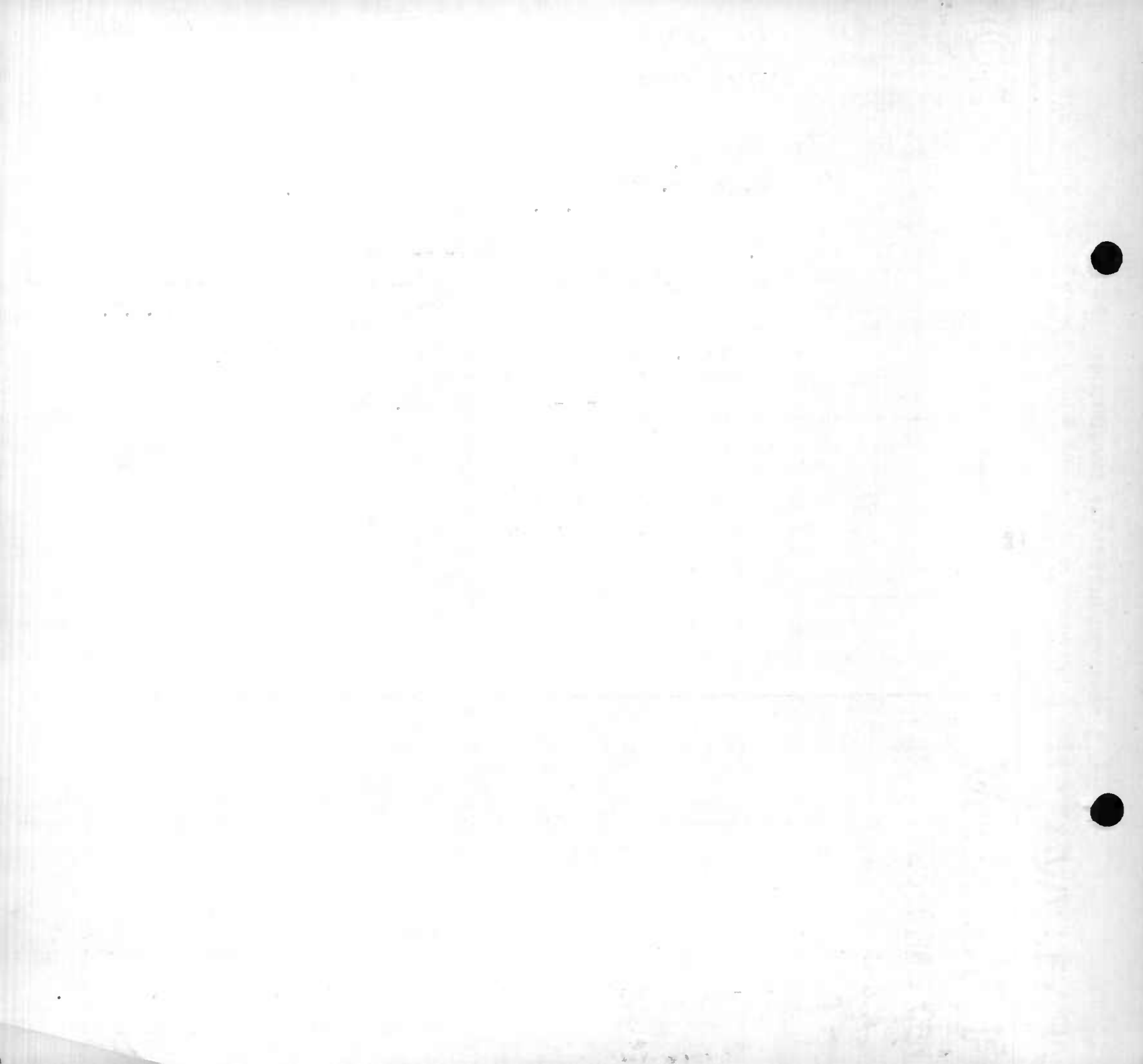
5-530 70 3002		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3002	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SMITH, EVA VIRGINIA		MARCH 9, 1970 4:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
ST AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY Howard Co. 6300		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
WILKENS & CATON AVENUES			WATERLOO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
BALTIMORE MARYLAND 21229			E. STREET AND NUMBER		
			BOX 290 WATERLOO ROAD		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	04-01-20	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Name		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
REZIN D. LOWMAN		(TURNER) SAVANNAH		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				RECORD'S BALTIMORE MD 21229	
				ST AGNES HOSPITAL WILKENS & CATON AVE	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Impaired Infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ASCVD & Atrial Fibrillation		
II			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 4, 1970 to MARCH 9, 1970 that (X) (we) last saw the deceased alive on MARCH 9, 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Hermenegildo N. Iridro M.D.				March 9, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
HERMEGENEGILDO N. Iridro M.D.				BALTIMORE MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/11/70		Madamridge Memorial Park Dorsey Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 23 1970		J. H. J. H.		J. H. J. H.	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

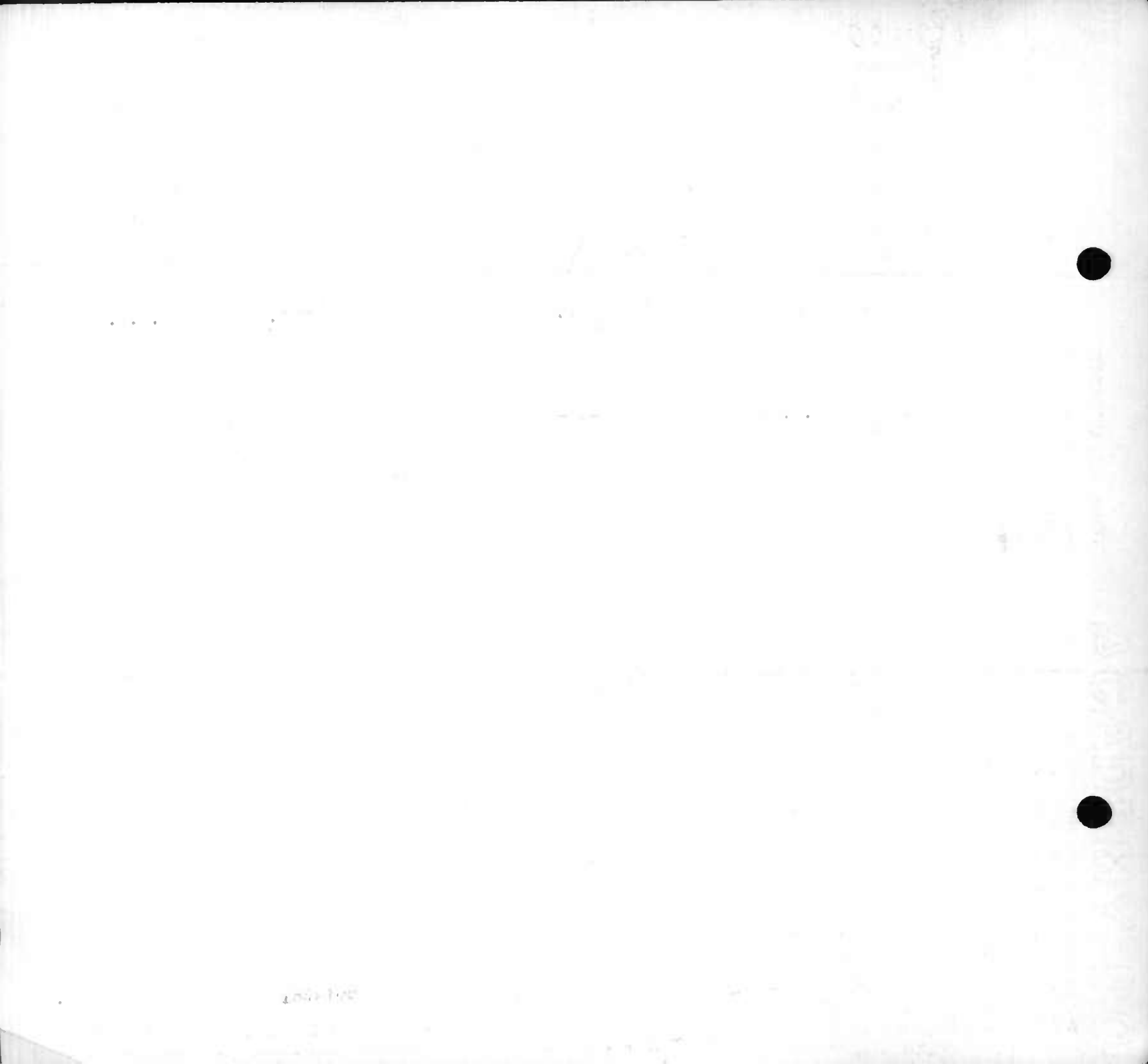
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3003</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Lillian James</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/17/70</span> <span style="font-size: 1.5em;">2 A</span> M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">S. Way</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">00 371 Homeland S. Way Apt. 3A.</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">2711</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">S. Way 371 Homeland Avenue</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Cau.</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">4-6-1893</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">76</span>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Secretary</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Woodery Mills</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Gustavus B. James</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Elizabeth Kelley</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">212-09-0658A</span>			<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Henry W. Morris 1357 Halstead Road 21234</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 15%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">10 hrs</span> </div> </div> <div style="margin-top: 10px;"> <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em; font-family: cursive;">Myocardial Infarction</span> </div> <div style="margin-top: 10px;"> <b>(B) ANTECEDENT CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em; font-family: cursive;">Arteriosclerotic Hypertension</span> </div> <div style="margin-top: 10px;"> <b>(C) ANTECEDENT CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em; font-family: cursive;">Cardiovascular Dis.</span> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Sept 1969</span> <b>to</b> <span style="font-size: 1.2em;">March 17 1970</span> , <b>that (I) (we) lost saw the deceased alive on</b> <span style="font-size: 1.2em;">March 6 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">Chas E. Carr Jr</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/17/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">CHAS E. CARR JR.</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">3900 N. CHARLES ST BALTO MD</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3-20-1970</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Parkwood Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Parkville Balto. Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 23 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">John E. Kelly</span>			
<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Lassahn Funeral Home 7401 Belair Road 2123</span>					



# FUNERAL DIRECTOR: IMPORTANT

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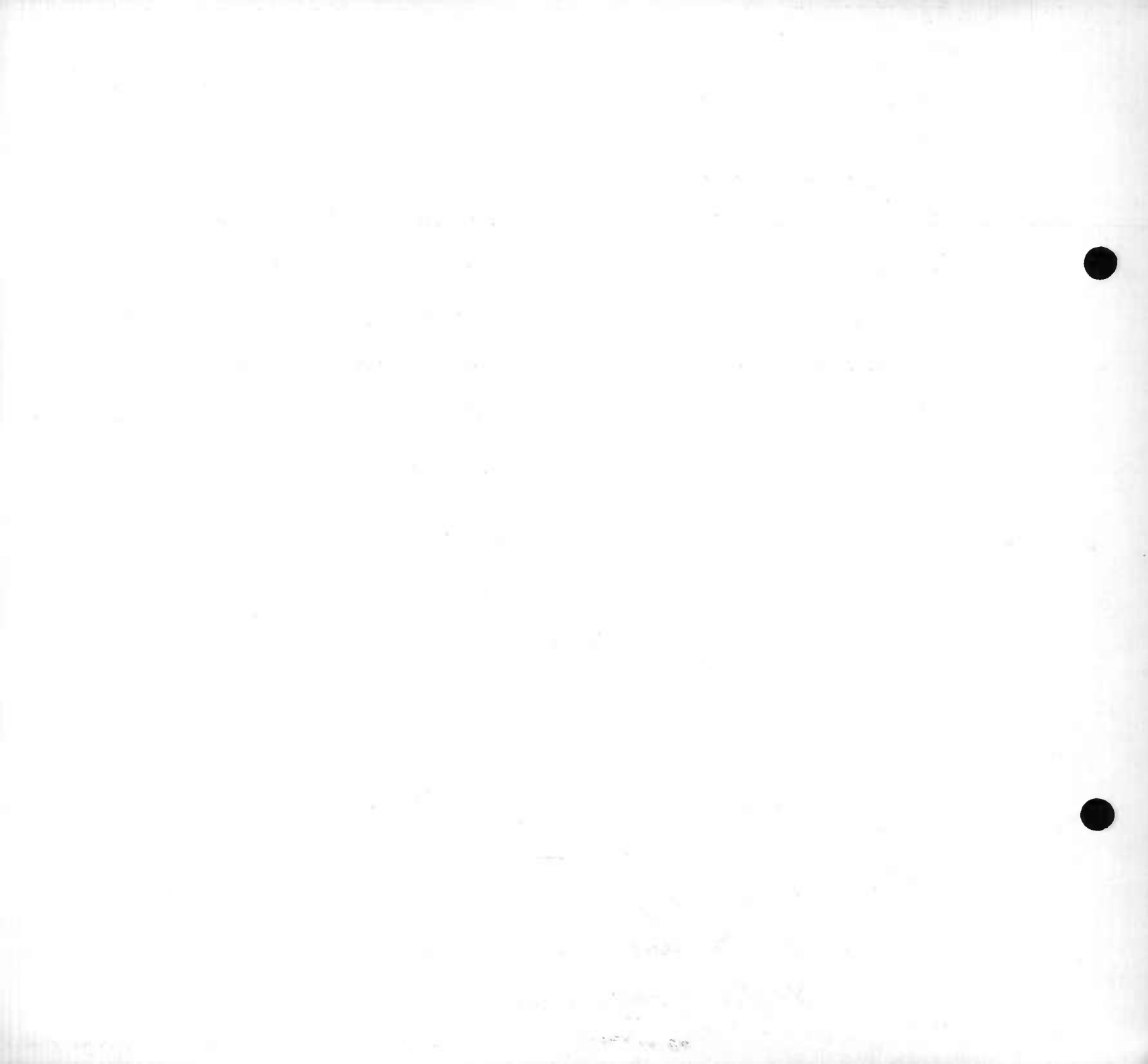
B-620 70 3004		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 3004	
1. NAME OF DECEASED (Type or Print) <b>BEVERLY M. BOWERS</b>		2. DATE AND HOUR OF DEATH <b>3/18/70 9:07 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3 GENTIAN LANE 21220</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/10/08</b>	9. AGE (in years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Mac Millan Co.</b>		11. BIRTHPLACE (State or foreign country) <b>USA. Tenna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES BOWERS</b>			
14. MOTHER'S MAIDEN NAME <b>AMANDA WIEGGER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.11</b>			
16. SOCIAL SECURITY NO. <b>411-10-0870</b>		17. INFORMANT <b>PATIENT Rose Bowers 3 Gentian Lane</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMATOSIS (PRIMARY UNKNOWN)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Intestinal obstruction with Bile</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/31/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LESIONS OF RIB &amp; TISSUE DE</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/23 1970</b> to <b>3/18 1970</b> that (I) (we) last saw the deceased alive on <b>3/18/70 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael F. Whitworth M.D.</b>		23B. DATE SIGNED <b>3/18/70</b>		23C. PHYSICIAN'S NAME (Type) <b>MICHAEL F. WHITWORTH M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-22-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glenwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Bristol Tenna.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>		25C. FUNERAL DIRECTOR <b>Classen H 7401 18th St</b>			



# FUNERAL DIRECTOR: IMPORTANT

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C-150 70 3005		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3005	
1. NAME OF DECEASED (Type or Print) <b>GEORGIA COVAN</b>		2. DATE AND HOUR OF DEATH <b>3/20/70 4:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 HOWE IN PINES 5837 BELAIR ROAD</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>SPARROWS POINT</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>ROUTE 10 - BOX 313B</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 10 1870</b>	9. AGE (In years last birthday) <b>100</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>	
13. FATHER'S NAME <b>GEORGE E. MARSHALL</b>		14. MOTHER'S MAIDEN NAME <b>MILVERA SANDERS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS LAURA BROWN</b> ADDRESS <b>ROUTE 10 BOX 313B-2019</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Post-Pericarditis</b>		<b>1 month</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cachexia</b>		<b>&gt; 2 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <b>Granulosa Anterior, Arteriosclerosis</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the doctor) attended the deceased from <b>2/27/70</b> to <b>3/20/70</b> that (I) (we) last saw the deceased alive on <b>3/18/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>3/20/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ALBERT BRADLEY MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE</b>	
24D. LOCATION (City, town, or county) (State) <b>DORSEY MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>	
25C. FUNERAL DIRECTOR <b>WILLIAM FUNERAL HOME - DUNDOWN MD</b>		25D. ADDRESS			

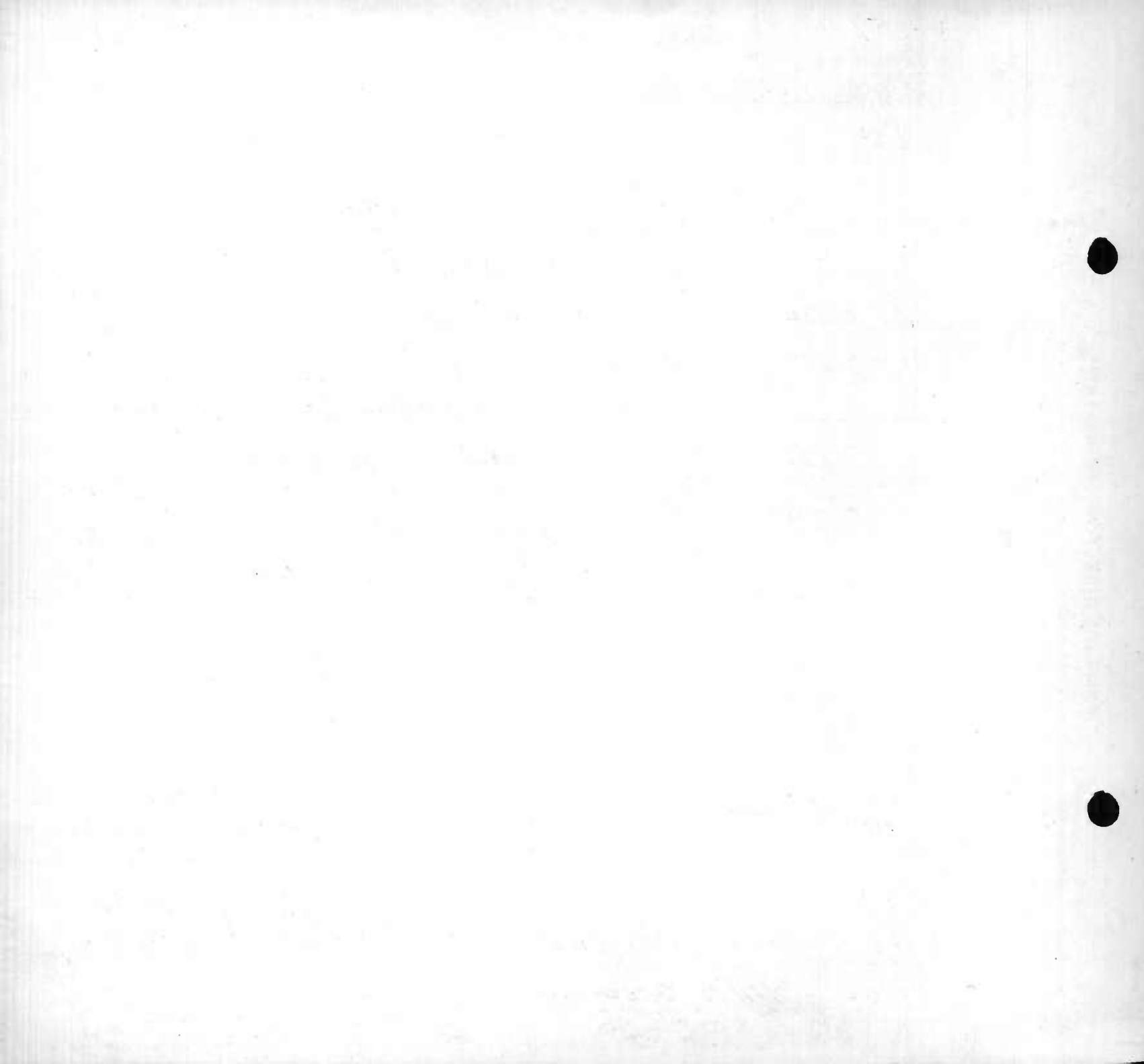




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-151 70 3006				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 631 70 3006	
1. NAME OF DECEASED (Type or Print) <b>MARY DOVENBARGER</b>				2. DATE AND HOUR OF DEATH <b>3/18/70 9 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Harbor View Nursing Home 1213 Light St</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Pratt</b> C. CITY OR TOWN <b>Belts</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>93 Willow Spring</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/87</b>		9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Burk</b>			14. MOTHER'S MAIDEN NAME <b>Addie Rohrbach</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>891-32-3366A</b>		17. INFORMANT <b>MRS MARIE DEBUS 93 WILLOW SPRING</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD - Cerebral A.S.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Recent CVA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>		(C) <b>Diabetes Mellitus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/14</b> 19 <b>70</b> to <b>3/18</b> 19 <b>70</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/18</b> 19 <b>70</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <b>P.C. Alvarez MD</b>				23B. DATE SIGNED <b>3/20/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>A.C. ALEVIZATOS MD</b>				23D. ADDRESS <b>1205 S Paul St. Belts, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/21/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENWOOD</b>		24D. LOCATION (City, town, or county) (State) <b>ZANESVILLE OHIO</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME</b> <b>1000 BUND ALK MD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3007</u>	
BIRTH NO. <u>70-03226 3007</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>RECKLINE, BABY BOY</b>			2. DATE AND HOUR OF DEATH <b>MARCH 19, 1970 1:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2005</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2608 LEHMAN STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03 18 70</b>	9. AGE (In years last birthday) <b>1</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>John Anthony De Antonis</b>			14. MOTHER'S MAIDEN NAME <b>GEORGIA A RECKLINE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		
17. INFORMANT <b>ST AGNES RECORDS-BALTO MD 21229</b>			ADDRESS		
18. <b>741.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>CONGENITAL HYDROCEPHALUS</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>CONG. MENINGOMYLOCELE</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>MARCH 18 1970</b> to <b>MARCH 19 1970</b> that (X) (we) last saw the deceased alive on <b>MARCH 19 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jorge E. Garcia</b>				23B. DATE SIGNED <b>3-19-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JORGE E. GARCIA</b>				23D. ADDRESS <b>ST. AGNES HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/21/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Green Haven Cem.</b>	
24D. LOCATION <b>Ritchie Hwy. Glen Burnie Md.</b>		24E. CITY, TOWN, OR COUNTY (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1970</b>		25B. NAME OF REGISTRAR <b>John J. Corvan</b>		25C. FUNERAL DIRECTOR <b>John J. Corvan</b>	
25D. ADDRESS					

2608 Lehman St.

called hospital

ET

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3008

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Neill

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3-30-70  
South Baltimore General3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Jan. 7, 1870-

10. AGE (In years  
lost birthday)

80

# Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

429 Gittings St.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Patrick Neill

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pipe Fitter-Ret.

14B. KIND OF BUSINESS OR INDUSTRY

Gas. &amp; Elec. Co.

15. MOTHER'S MAIDEN NAME

Therese Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Charles J. Neill 5454 Addington Rd.

19. CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Hanging

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

429 Gittings St. 2402

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

3 20 70 8:00a m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

hanged self

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

3/20/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3 24 70

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Mc Gully

ADDRESS

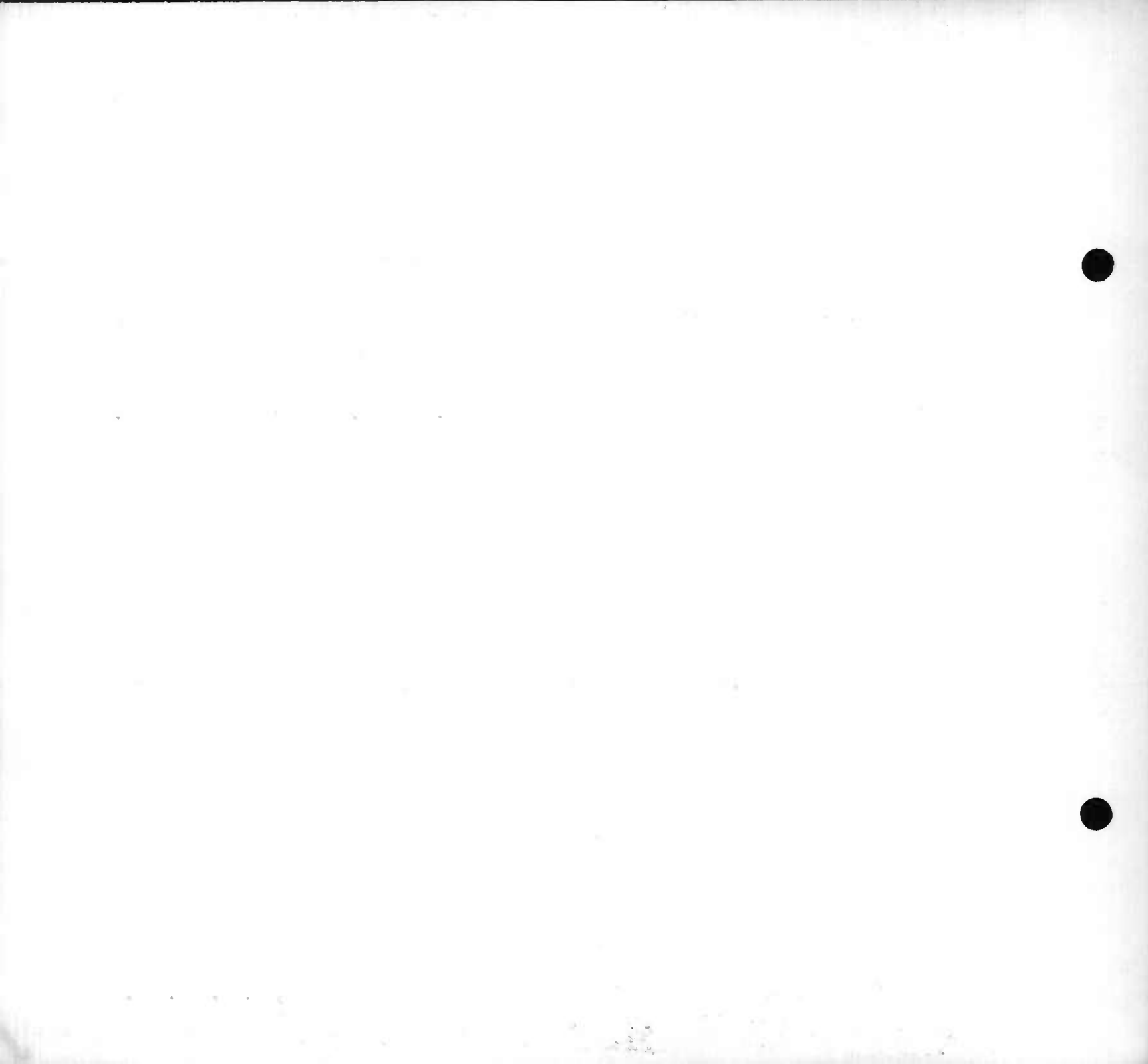
130 E. Fort Ave

Marriage Verification from Court House for  
James Neill - age 24 yrs. on June 17, 1914.  
and V.S. 153 3-30-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-460		70 3009		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3009	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>WEILER, PETER - S.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>6:15 PM 13/21/70</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2403</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>8-18-92</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator-Barge</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>George (Dec)</b>				14. MOTHER'S MAIDEN NAME <b>MARY HOLLY (Dec)</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-03-8866</b>		17. INFORMANT ADDRESS <b>A Mrs. Edna M. Weiler 1229 Wall St.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Min</b>	
(B) <b>Ca. of asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>6:15 PM 3/21 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dhanbir S. Saluja</b>				23B. DATE SIGNED <b>3/21/70</b>		23C. PHYSICIAN'S NAME (Type) <b>DHANBIR S. SALUJA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3 25 70</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>		25C. FUNERAL DIRECTOR <b>McCallby</b>	
24D. LOCATION <b>Brooklyn, A. A. Co. Md.</b>				25D. ADDRESS <b>-130 E. Federal Ave, 21230</b>			



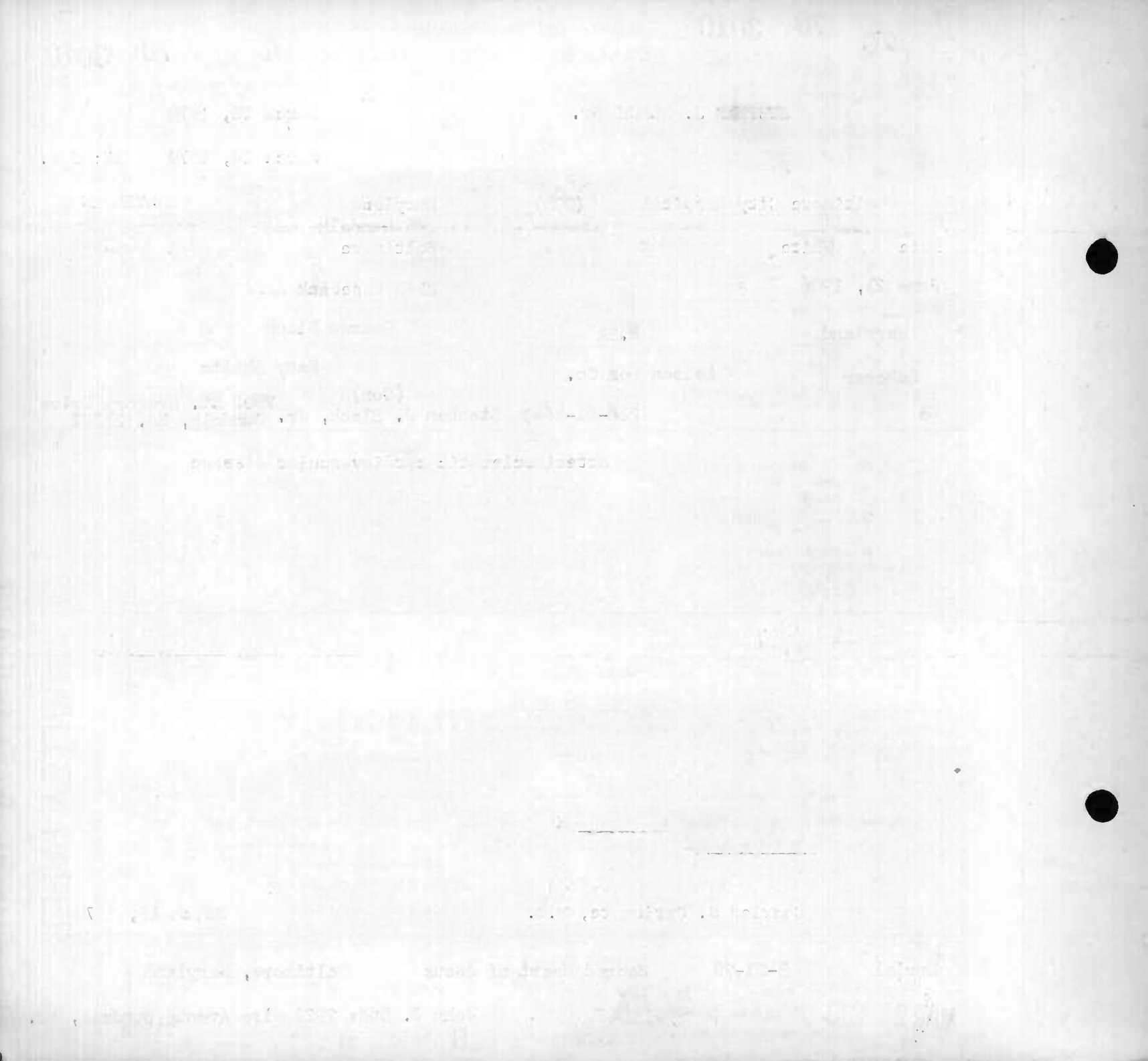


1 **B-420** 70 3010 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **70 3010**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>STEPHEN J. BLACK Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 18, 1970</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 18, 1970 12:35 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b>	
9. DATE OF BIRTH <b>June 21, 1906</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Nelson Box Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-01-4643</b>	
13. FATHER'S NAME <b>George Black</b>		15. MOTHER'S MAIDEN NAME <b>Mary Shultz</b>	
18. INFORMANT (Son) <b>Stephen J. Black, Jr.</b>		ADDRESS <b>7802 St. Gregory Drive, Dundalk, Md. 21222</b>	

19. <b>412.4</b> CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 19, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-21-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Avenue, Dundalk, Md. 21222</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 3011</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">H-309 70 3011</span> <span style="font-size: 1.2em;">70-05844</span>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> Wayne William Lee Hewett		<b>2. DATE AND HOUR OF DEATH</b> MARCH 19, 1970 9:00 P. M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY 841 C. CITY OR TOWN: BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 2303 BELAIR ROAD		
<b>5. SEX</b> MALE	<b>6. RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 3-15-70	<b>9. AGE</b> (In years last birthday) ----- If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) none		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13. FATHER'S NAME</b> WAYNE HEWETT		<b>14. MOTHER'S MAIDEN NAME</b> MARY QUINN		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Wayne Hewett, father, above
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-RESPIRATORY ARREST INTRA-CRANIAL HEMORRHAGE (B) PREMATURE DUE TO, OR AS A CONSEQUENCE OF: (C)	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			RESPIRATORY DISTRESS HYPERBILIRUBINEMIA - EXCHANGE TRANSFUSION 8 HOURS	
<b>19A. DATE OF OPERATION</b> 3/19/70		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> HYPERBILIRUBINEMIA		<b>20A. AUTOPSY?</b> (Yes or No) No
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) No		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		22. I certify that (I) (this hospital) attended the deceased from MARCH 15 19 70 to MARCH 19 19 70 that (I) (we) last saw the deceased alive on MARCH 19 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
<b>23A. SIGNATURE</b> Lee Nedengard M.D.		<b>23B. DATE SIGNED</b> March 19, 1970		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
<b>23C. PHYSICIAN'S NAME</b> (Type) LEE NEDENGARD		<b>23D. ADDRESS</b> THE JOHNS HOPKINS HOSPITAL		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> 3/20/70		<b>24C. NAME of CEMETERY or CREMATORY</b> Holy Redeemer Cemetery
<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Md.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> MAR 23 1970		
<b>25B. NAME OF REGISTRAR</b> Robert E. Fisher, M.D.		<b>25C. FUNERAL DIRECTOR</b> Schimunek Funeral Home, Inc. 8331 Brehms Lane		



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3012</b>	
<b>M-620</b> BIRTH NO. <b>70 3012</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>BARRETT, E. MARK</b>			2. DATE AND HOUR OF DEATH <b>3-20-70 10.50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (Type or Print) <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b> ADDRESS OR LOCATION <b>460 3-26-70</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore, Md</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>396 FIRST AVE</b>		
5. SEX <b>MALE</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-9-84</b> 9. AGE (In years last birthday) <b>85</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Both Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Polk Barrett</b>		
14. MOTHER'S MAIDEN NAME <b>Tanner</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Mark S Barrett 204 Hollyberry Rd Sev Pk, Md</b>			17. INFORMANT ADDRESS <b>Mark S Barrett 204 Hollyberry Rd Sev Pk, Md</b>		
18. <b>1835 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Carcinoma of</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Prostate with secondary deposits.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTICIPATED CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>3-20-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostate</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Lutheran Hospital</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Lutheran Hosp. Balto.</b>	
21D. TIME OF INJURY (APPROX.) <b>3-20-70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Prostate</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>3-9-70</b> to <b>3-20-70</b> , that (1) (we) last saw the deceased alive on <b>3-20-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Nanes M.D.</b>				23B. DATE SIGNED <b>3-20-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. Nanes M.D.</b>				23D. ADDRESS <b>Lutheran Hospital Balto.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem Pk</b>	
24D. LOCATION <b>Glen Burnie AA Co Md</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>MAR 23 1970</b>			
25B. NAME OF REGISTRAR <b>McBulley F.H.</b>		25C. FUNERAL DIRECTOR <b>Paterson one 717/75</b>			

VS 153 3-26-70 M.H.

RECEIVED

DATE M

X

10-8-41 22

200 LINDY N/A

Proclamation 4411

X

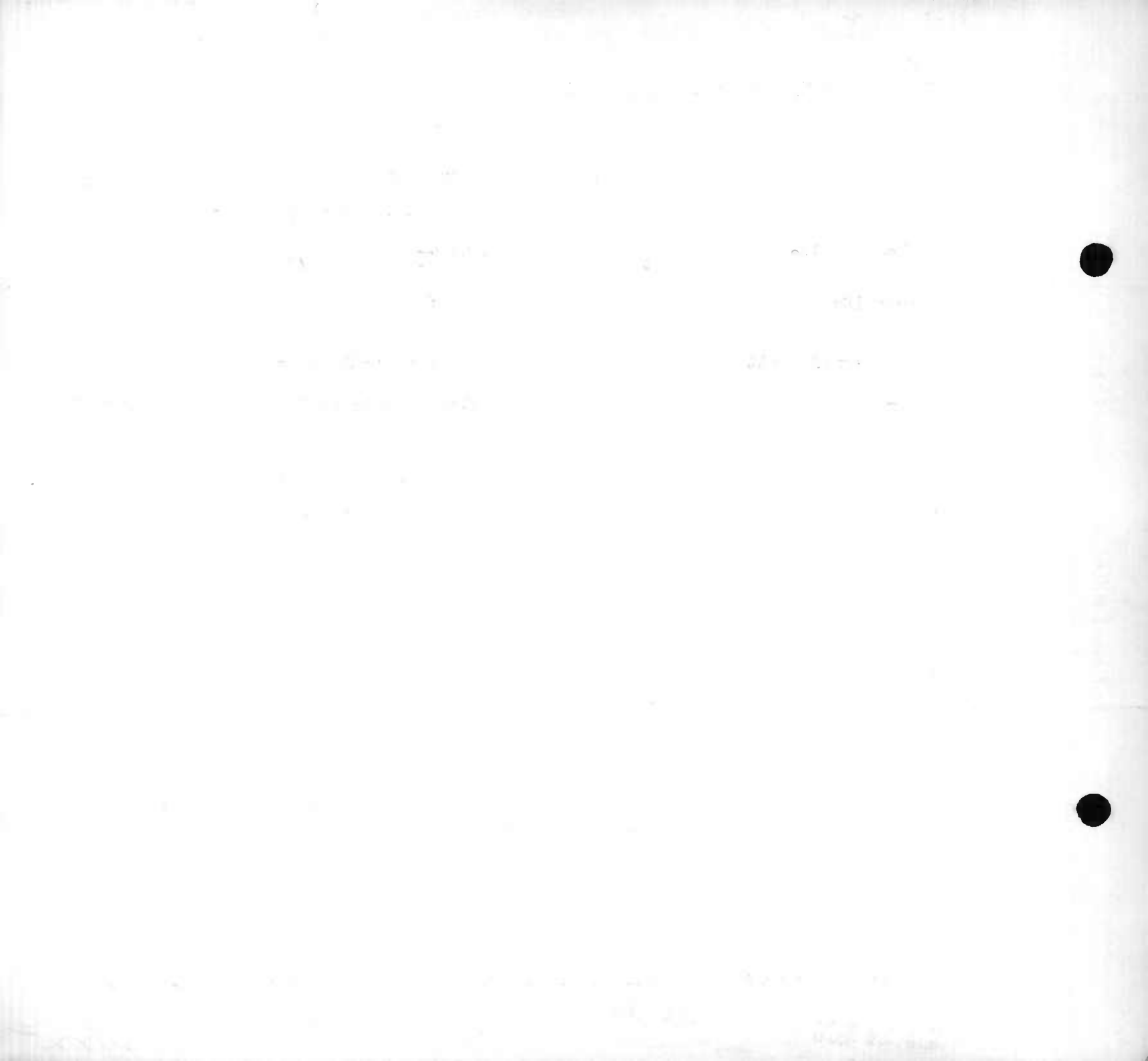
RECEIVED

DATE M

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>W-232</b>		70 3013		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. <b>70 3013</b>	
1. NAME OF DECEASED (Type or Print) <b>MRS. Ruth L. Westcoat</b>				2. DATE AND HOUR OF DEATH <b>3-21-70 3:00 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Md</b>		B. COUNTY <b>AA Co.</b>	
				C. CITY OR TOWN <b>Brooklyn</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <b>106 Cedar Hill Rd 21225</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/22/23</b>		9. AGE (in years last birthday) <b>47</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gerald Scott</b>				14. MOTHER'S MAIDEN NAME <b>Ada Scott Loppo</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Allan J Westcoat 106 Cedar Hill Rd 21225</b>			
18. <b>4-20-70 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b>				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Subarachnoid hemorrhage</b>					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>Chole</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-12</b> 19 <b>70</b> to <b>3-21</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>M. Buchness M.D.</b>				23B. DATE SIGNED <b>3-21-70</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>			
23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Co Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert F. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>McBully F. H.</b>		25D. ADDRESS <b>37 Patuxent Ave 712725</b>			

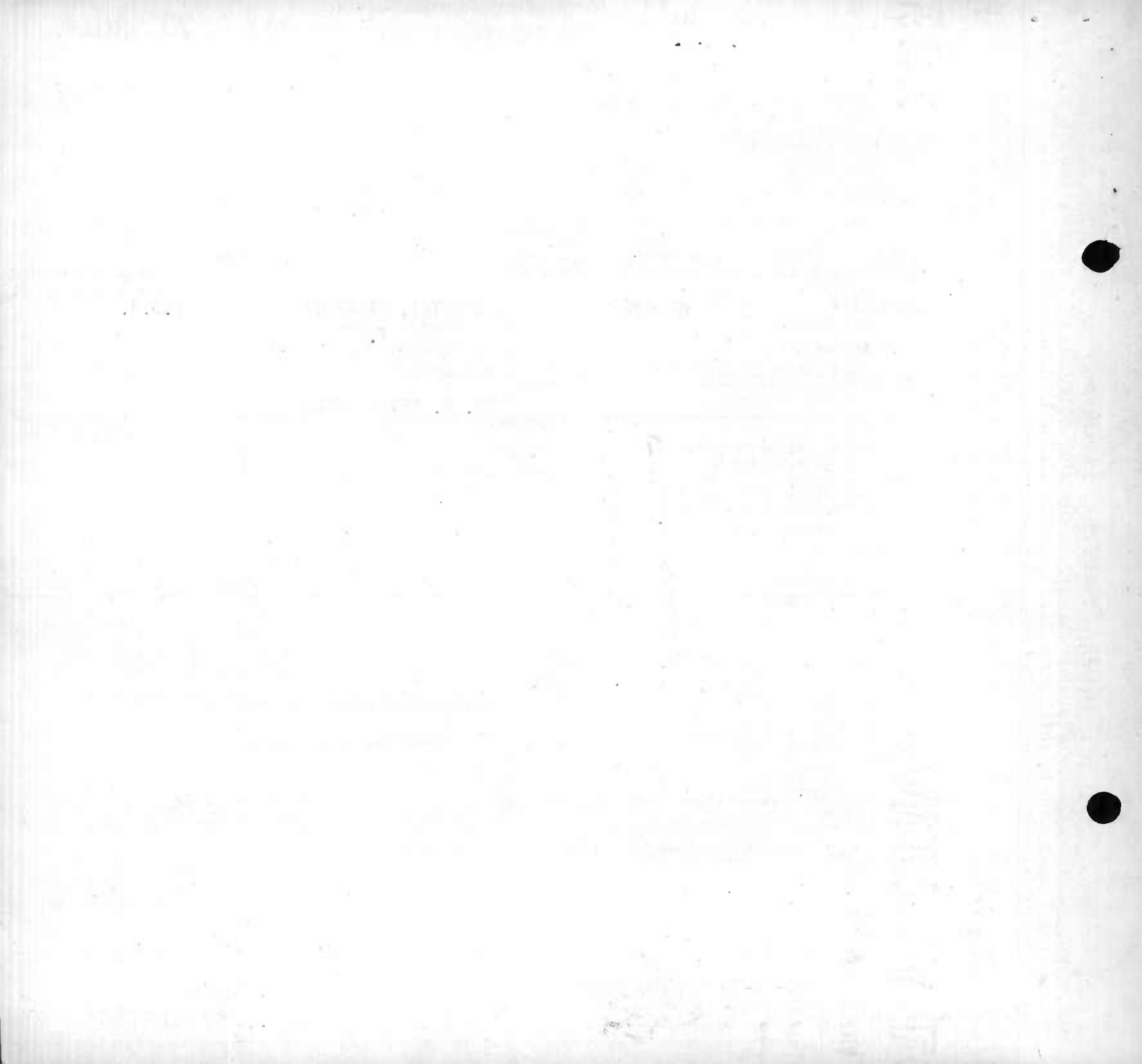




## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3014	
K-500 70 3014		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KOHN, Hylda			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 3/19/70 1205 P M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2711			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		9. AGE (In years lost birthday) 61 XXX	
13. FATHER'S NAME Meyer Gutman		11. BIRTHPLACE (State or foreign country) BRISTOL, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. M. PETER MOSER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) INSPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) PERFORATION OF ESOPHAGUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 MIN 5 days 5 days	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/13		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED ESOPHAGUS		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital 06-05	
21D. TIME OF INJURY (APPROX.) 3-13-70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Perforation of Esophagus during Esophagoscopy	
22. I certify that (1) (this hospital) attended the deceased from 3/13 1970 to 3/19 1970, that (1) (we) lost the deceased alive on 3/19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Reynolds, M.D.				23B. DATE SIGNED 3/19/70	
23C. PHYSICIAN'S NAME (Type) James Reynolds, M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-20-70		24C. NAME OF CEMETERY or CREMATORY HAR SINAI	
24D. LOCATION BALTIMORE, MARYLAND		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3015</u>
BIRTH NO. <u>N-120</u>		70 3015		
1. NAME OF DECEASED (Type or Print) <u>William NAVIASKY</u>		2. DATE AND HOUR OF DEATH <u>3-18-70 11:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6628 VINCENT LANE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-45</u> 9. AGE (in years) <u>24</u> 10. MONTH <u>XX</u> DAY <u>XX</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>EMPLOYED</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>XXXX UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-10-9140</u>		17. INFORMANT <u>MR. NORTON NAVIASKY, 3916 LABYRINTH RD. #15</u>
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Altered heart heart disease</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Obstructive Airways Disease</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Obstructive Airways Disease</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3/18/70</u> 19 <u>70</u> to <u>3/18</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/18/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date <u>11:30 A.M.</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>PR Donovan</u>		23B. DATE SIGNED <u>3-18-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>PR Donovan</u>		23D. ADDRESS <u>Sinai Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3-19-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>SHAAREI ZION</u>	24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		
		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		

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p-645

70

3016

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3016

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JACK <del>PERLMAN</del> PERLMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 17, 1970 5:00 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12-11-1906</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MR. RAY S. GOULD, 1 CHARLES CENTER #1</b>		ADDRESS	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest complicating Arteriosclerotic</b> (A) IMMEDIATE CAUSE <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bleeding gastric ulcer</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3/18/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-19-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. Kelly, Jr.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	

11-11-1968

WASHINGTON, D.C.

MEMORANDUM

TO :

FROM :

MR. SAUNDERS, 1000 10th Street, N.W.

WALL

*[Handwritten signature]*

11-11-1968

WASHINGTON, D.C.

MEMORANDUM

TO :

FROM :

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3017</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">S-632</span>		<b>70 3017</b>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <span style="font-size: 1.5em;">William Schwartzman</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.5em;">March 19, 1970 4 P. M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> <span style="font-size: 1.5em;">42 Sinner Hospital</span>			<b>4. USUAL RESIDENCE</b> <small>(Where deceased lived. If institution: residence before admission)</small> <b>A. STATE</b> <span style="font-size: 1.5em;">MARYLAND</span> <b>B. COUNTY</b> <span style="font-size: 1.5em;">2730</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.5em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.5em;">3901 PINKNEY ROAD, APT. 10</span>		
<b>5. SEX</b> <span style="font-size: 1.5em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">4-16-1898</span>	<b>9. AGE</b> <small>(In years last birthday)</small> <span style="font-size: 1.5em;">71</span>	<b>10. USUAL OCCUPATION</b> <small>(Give kind of work done during most of working life, even if retired)</small> <span style="font-size: 1.5em;">EMPLOYEE</span>
<b>10A. USUAL OCCUPATION</b> <small>(Give kind of work done during most of working life, even if retired)</small> <span style="font-size: 1.5em;">EMPLOYEE</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">STEEL WORKER</span>		<b>11. BIRTHPLACE</b> <small>(State or foreign country)</small> <span style="font-size: 1.5em;">BALTIMORE, MARYLAND</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.5em;">JOSEPH SCHWARTZMAN</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.5em;">UNKNOWN</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <span style="font-size: 1.5em;">NO</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.5em;">213-16-6054A</span>			<b>17. INFORMANT</b> <b>ADDRESS</b> <span style="font-size: 1.5em;">MRS. FANNIE SCHWARTZMAN, 3901 PINKNEY RD., APT. 10</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <span style="font-size: 1.5em;">41241</span>			<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.5em;">Pulmonary embolism</span> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) Chronic congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) Arteriosclerotic cardiovascular disease</b>		
<b>19. DATE OF OPERATION</b> <span style="font-size: 1.5em;">0</span>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> <small>(Yes or No)</small> <input type="checkbox"/>			<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <small>(notify medical examiner)</small> <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		
<b>21C. WHERE DID INJURY OCCUR?</b> <small>(If in Baltimore City, give exact location)</small>			<b>21D. TIME OF INJURY</b> <small>(APPROX.)</small> <span style="font-size: 1.5em;">(Month) (Day) (Year) (Hour)</span>		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (the hospital) attended the deceased from <span style="font-size: 1.5em;">1965</span> to <span style="font-size: 1.5em;">March 19, 1970</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">March 19, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Seymour H. Rubinstein</span>			<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">3/19/70</span>		
<b>23C. PHYSICIAN'S NAME</b> <small>(Type)</small> <span style="font-size: 1.5em;">Seymour H. Rubinstein</span>			<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">5415 Park Heights Rd, Baltimore, MD 21215</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> <small>(Specify)</small> <span style="font-size: 1.5em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.5em;">3-20-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.5em;">RUDOMER VEREIN</span>	
<b>24D. LOCATION</b> <small>(City, town, or county)</small> <span style="font-size: 1.5em;">ROSEDALE, MARYLAND</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">MAR 23 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">Blair E. Taylor, JR.</span>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <span style="font-size: 1.5em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>			





# FUNERAL DIRECTOR: IMPORTANT

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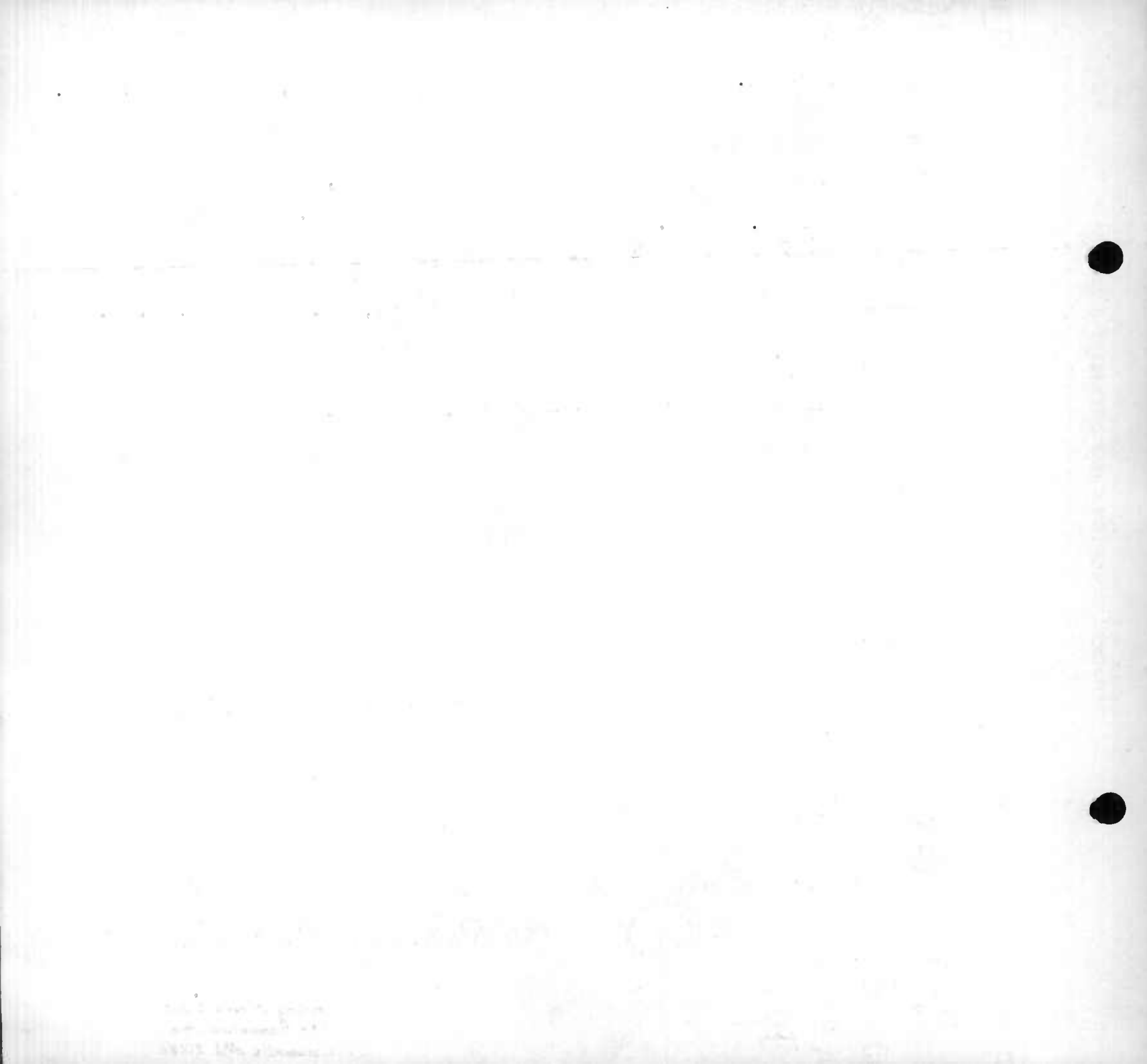
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3018	
J-520 70 3018		CERIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES, REBECCA B.		MARCH 19, 1970 7:00 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
40 ST AGNES HOSPITAL		MARYLAND Baltimore 5300			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		18 MAPLE DRIVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	01 31 97	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED-STENOGRAPHER		B & O RR		WASHINGTON DC	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANK BAKER		DORA PIMES		U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST AGNES RECORDS-BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 21 19 70 to MARCH 19 19 70 that (X) (we) last saw the deceased alive on MARCH 19 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
DR. ALONSO		03/19/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. ALONSO		ST AGNES HOSPITAL BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3/23/70		Loudon PK Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 23 1970		Edward Mac Nabbs		301 Frederick Rd 21228	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 3019</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">70 3019</span>	
1. NAME OF DECEASED (Type or Print) <i>Mildred M. Lauer</i>			2. DATE AND HOUR OF DEATH <i>March 20, 1970 12:30 A.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Hood Nursing Home 5313 Edmondson Avenue Baltimore, Md. 21229</i>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Catonsville, Md</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>11 Delrey Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/28/04</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>William G. Lauer</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Devan</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-44-9894</i>	17. INFORMANT <i>Mrs. Lillian E. Presson-11 Delrey Ave</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) <i>Arteriosclerosis</i> (C) -----		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>4 years</i>					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). -----					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>March 19</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>L. A. Lally MD</i>				23B. DATE SIGNED <i>Mar 20 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>L.A. LALLY</i>				23D. ADDRESS <i>MD ROLLING Rd. FREDERICK Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/21/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1970</i>			
25A. NAME OF REGISTRAR <i>236 Edmondson Ave.</i>		25B. FUNERAL DIRECTOR <i>STERLING FUNERAL EST</i>		25C. ADDRESS <i>Catonsville, Md. 21228</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

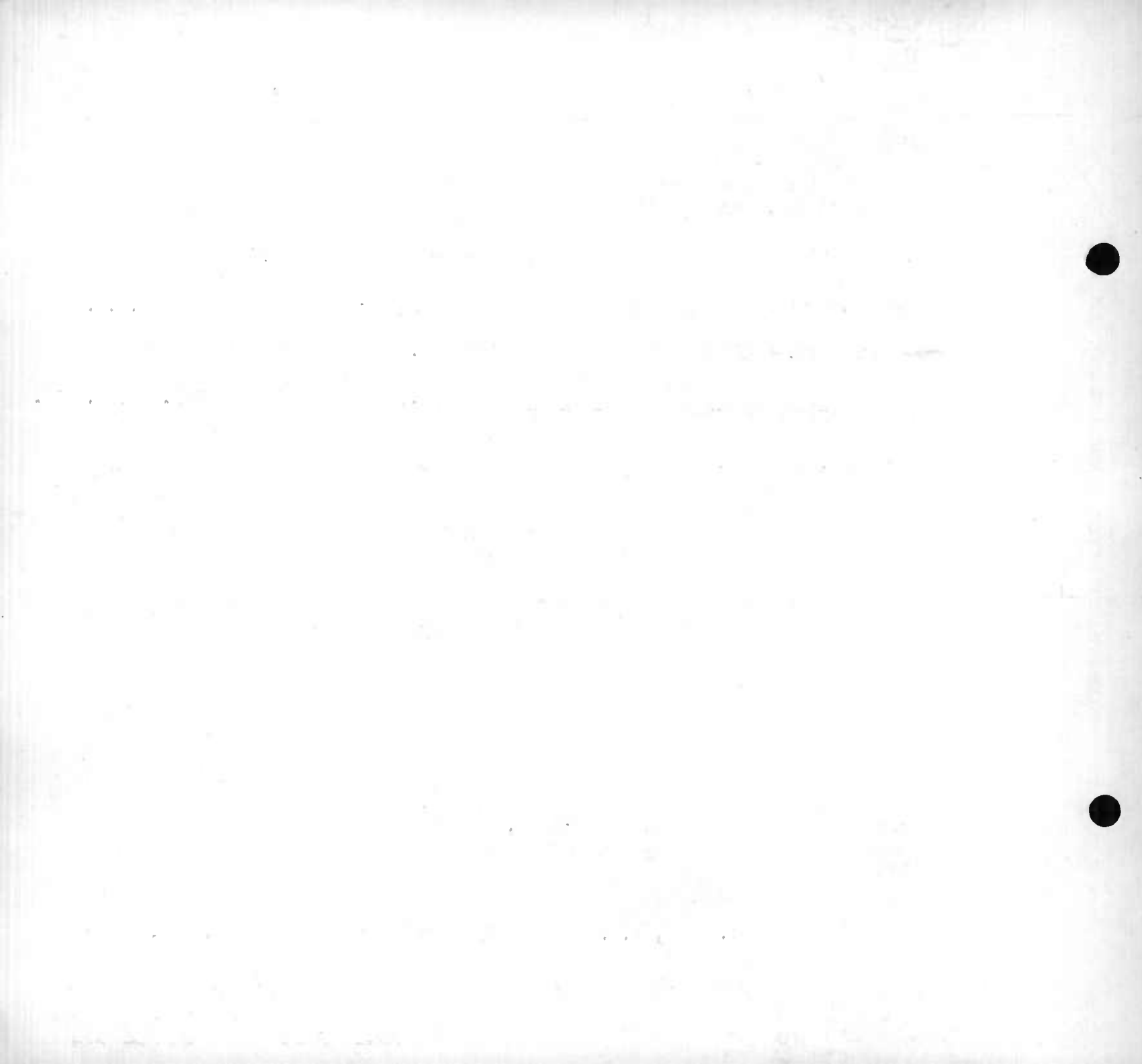
V-250 70 3020		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3020	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Roy Vaughn			
2. DATE AND HOUR OF DEATH 3/18/70 7:10 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 377 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel 5200 C. CITY OR TOWN Edgewater D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. #3 Box 3L			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/21		9. AGE (In years lost birthday) 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Vaughn				14. MOTHER'S MAIDEN NAME Abbie Watts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. +15-22-6385		17. INFORMANT Mrs. R. Vaughn		ADDRESS Same	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung & esophagus (B) Hyperealcemia 2° to DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos 1 wk	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (Name of hospital) attended the deceased from 3/16 19 70 to 3/18 19 70 that (1) (Name) last saw the deceased alive on 3/18 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (See) (did) (did not) view the body after death.							
23A. SIGNATURE Richard H. Baur M.D.				23B. DATE SIGNED 3/18/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Mar 21 1970		Savage Cemetery		Savage, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
MAR 23 1970		Charles E. ...		Beall Funeral Home 1212 West St Anna			

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 3021	
<div style="display: flex; justify-content: space-between;"> <span>D-500 70 3021</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>							
1. NAME OF DECEASED (Type or Print) <b>DUNN, JOSEPH RAYMOND</b>				2. DATE AND HOUR OF DEATH <b>march 18, 1970 7:00P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>12-23-15</b>		9. AGE (In years last birthday) <b>54</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Maryland State</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Dunn, IRA B</b>			
14. MOTHER'S MAIDEN NAME <b>Ethel M.</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6-1-45 to 8-25-46</b>			
16. SOCIAL SECURITY NO. <b>234-20-41-50</b>				17. INFORMANT <b>Records</b> ADDRESS <b>VA Hosp., 3900 Loch Raven Blvd. Balto., Md.</b>			
18. <b>593.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Advanced chronic renal insufficiency</b>				YEARS <b>Years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic heart disease</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>March 18, 70</b> to <b>March 18, 1970</b> , that (2) (we) lost saw the deceased alive on <b>March 18, 1970</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) <del>lost</del> <b>viewed</b> the body after death.							
23A. SIGNATURE  <b>YOUNG E. CHUN, M.D.</b>				23B. DATE SIGNED <b>3/19/70</b>		23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>E. S. Mac Nabb</b>		ADDRESS <b>3017 Frederick Rd Balto. Md</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3022	
K-523 70 3022				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ROBERT C. KNIGHT</b>			2. DATE AND HOUR OF DEATH <b>3-20-70 6:00 P.M.</b>		
3. PLACE IN <b>BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21227 Baltimore 5300</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Md. Hospital Baltimore 21201</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <b>1826 Winans Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-91</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert B Knight</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Bird</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>218-01-5243</b>		
17. INFORMANT <b>Hosp. Chart.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of prostate with widespread bony metastases</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic lymphocytic leukemia with profound anemia</b>			<b>2 mos</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Bronchitis</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Denied by Spouse</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from <b>Feb 27, 1970</b> to <b>March 20, 1970</b> that (we) last saw the deceased alive on <b>3-20 1970</b> and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Federick N. Pearson, M.D.</b>			23B. DATE SIGNED <b>3-20-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK N. PEARSON, M.D.</b>			23D. ADDRESS <b>U. of Md. Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>	<b>3/24/70</b>	<b>bedford Hill cemetery</b>		<b>Baltimore, Maryland</b>	
25A. DATE RECEIVED HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>MAR 23 1970</b>		<b>John E. Taylor, M.D.</b>		<b>Amberrose Inc 1322 Sulphur Spring Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 3023
V-240 70 3023		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Birdie Vosshell</i>		2. DATE AND HOUR OF DEATH <i>3/19/70 1120 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1547</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3025 Windsor Ave.</i>			
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>09-15-87</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>John Carter</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Cockey</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marion N. Vosshell</i>	
				ADDRESS <i>2137 Horace Ave. Abington Va.</i>	
18. <i>237.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Renal failure.</i> (B) <i>Tumor of the kidney</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>3-16-1970</i> to <i>3-19-1970</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>3-19-1970</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Suman Vongkasemsri</i> DEGREE				23B. DATE SIGNED <i>3-19-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>SUMAN VONGKASEMSRI</i> DEGREE				23D. ADDRESS <i>LUTHERAN HOSP.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3 23 70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i>	
24D. LOCATION <i>Brooklyn, A. A. Co. Md.</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert A. Kelly, MD</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>	
				ADDRESS <i>130 E. Fort Ave</i>	

Birdie Stowell

Baltimore Hospital

F. M.

Mr.

Baltimore

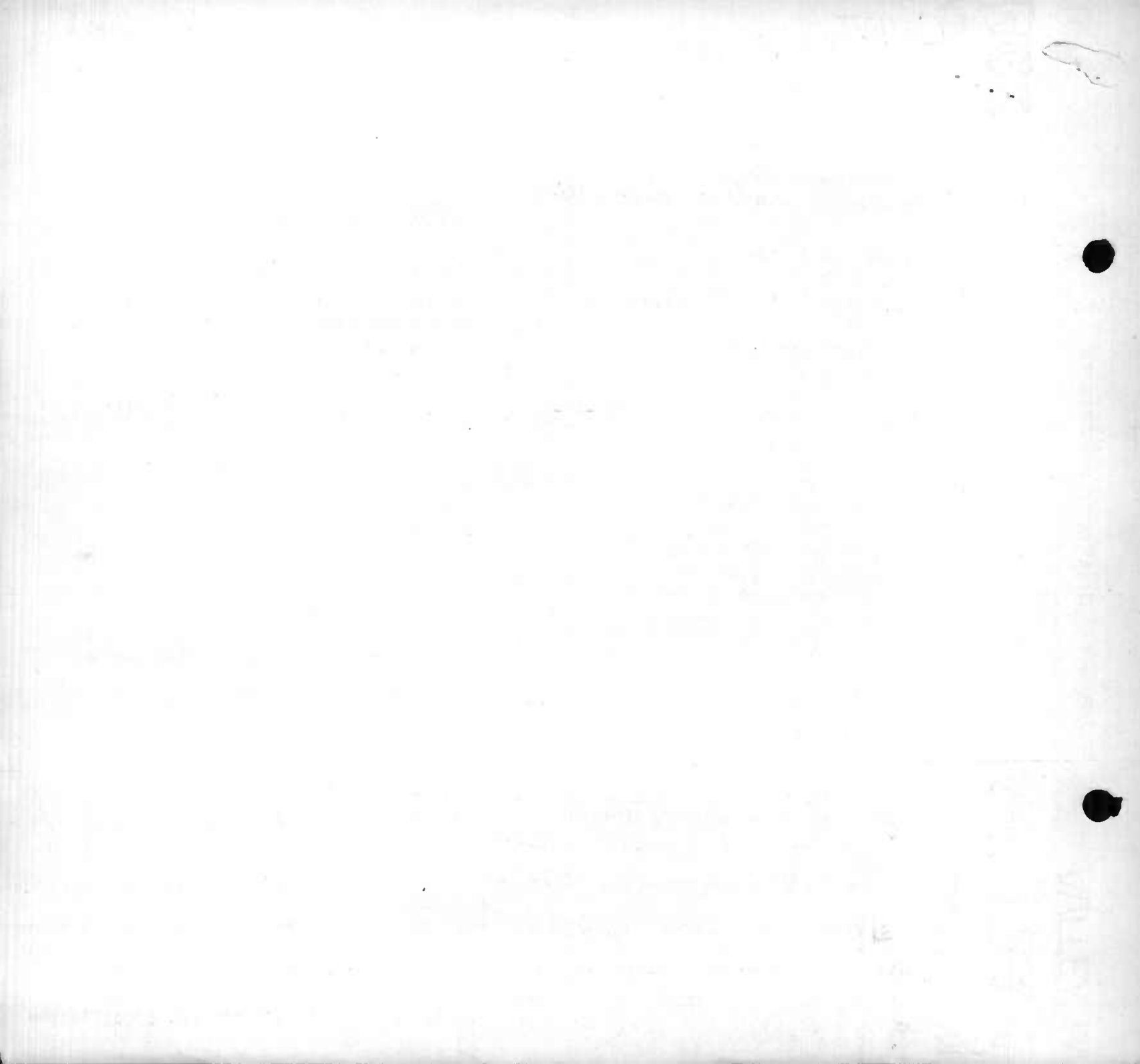
30 St. Vincent Ave.

09-12-87

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3024</span>	
<b>C-413</b> <b>70 3024</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>LORRAINE CLIFTON</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>MARCH 20, 1970 11:00 A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>LUTHERAN Hosp. of Md.</b> <b>730 Ashburtn St. Balto. Md.</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>B. COUNTY</b> <b>3727 Milford Mill Rd</b> <b>Baltimore</b> <b>Maryland 21207</b> <b>5300</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Upholstrey</b>		<b>8. DATE OF BIRTH</b> <b>9-22-25</b>	
<b>13. FATHER'S NAME</b> <b>Albert Lee Burkner</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Irene Ricker</b>		<b>9. AGE</b> (In years last birthday) <b>44</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Baryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-18-2650</b>		<b>17. INFORMANT</b> <b>Mr. Roy Clifton</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>RESPIRATORY ACIDOCIS</b> <b>CANCER OF THE LUNG 2 METASTASES</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital) attended the deceased from</b> <b>FEBRUARY 25, 1970</b> <b>to</b> <b>MARCH 20, 1970</b> <b>that</b> <input checked="" type="checkbox"/> <b>(we) last saw the deceased alive on</b> <b>MARCH 20, 1970</b> <b>and that</b> <input checked="" type="checkbox"/> <b>in</b> <b>(our) opinion death occurred on the date and hour and from the causes stated above.</b> <input checked="" type="checkbox"/> <b>(We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Christos Dibrancos, M.D.</b>				<b>23B. DATE SIGNED</b> <b>MARCH 20, 1970</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>CHRISTOS DIBRANCOS, M.D.</b>		<b>23D. ADDRESS</b> <b>730 ASHBURTON STR., BALTO., MD. 21216</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>3/23/70</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Druid Ridge Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Pikesville Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 23 1970</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Loring Byers</b>		<b>25C. FUNERAL DIRECTOR</b> <b>728 Liberty Rd. Randallstown</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-160		70 3025		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3025	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>KATHERINE COXWELL WEBER</u>			
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>MARCH 18, 1970</u> <u>3:35 PM</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>114</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2733</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1908</u> <u>MARCH 6, 1908</u> <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN M. DICKEY, SR.</u>				14. MOTHER'S MAIDEN NAME <u>KATE BAKER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-7883</u>		17. INFORMANT <u>JOHN DICKEY, JR. BALTO., MD</u>			
18. <u>431.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSE DISEASES OR CONDITIONS, any, giving rise to the above cause (i.e., stating the UNDERLYING CONDITION last.) <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA, Intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 18</u> 19 <u>70</u> to <u>MARCH 18</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MARCH 18</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. L. L. M. D.</u> MD				23B. DATE SIGNED <u>3-18-70</u>		23C. PHYSICIAN'S NAME (Type) <u>YU, SUN LIT MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/23/70.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25D. ADDRESS	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-520 70 3026				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 3026	
BIRTH NO.				CERTIFICATE OF DEATH			
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Maria Zang</i>				<b>2. DATE AND HOUR OF DEATH</b> <i>March 19, 1970 11:30 A.M.</i>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4914 Arabia Ave, Baltimore Md 21214</i>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2743</i> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>Baltimore</i> <b>6. STREET ADDRESS</b> (If rural, give location) <i>4914 Arabia Ave</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. RACE</b> <i>White</i>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <i>Widow</i>		<b>8. DATE OF BIRTH</b> <i>Nov 12 1898</i>	<b>9. AGE</b> (In years last birthday) <i>71</i>	<b>If Under 1 Yr.</b> Months: Days: Hours: Min.	<b>If Under 24 Hrs.</b> Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>W.F.</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Baltimore Md</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Philip Logue</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Ellen Donohue</i>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				<b>16. SOCIAL SECURITY NO.</b> <i>212-30-4459</i>		<b>17. INFORMANT</b> <i>Jeannie Borgerding</i>	
				<b>ADDRESS</b> <i>2316 Sedman Ave</i>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>CAUSE OF DEATH</b> (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Coronary atherosclerosis</i> DUE TO (C)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>4-12-1966</i> <b>to</b> <i>Feb 12 1970</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Feb 12 1970</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>Sebastian Russo</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				<b>23B. DATE SIGNED</b> <i>3/19/70</i>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>SEBASTIAN RUSSO</i> M.D.				<b>23D. ADDRESS</b> <i>5017 Harford Rd Baltimore Md</i>			
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>3/23/70</i>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Holy redeemer Cem.</i>		<b>24D. LOCATION</b> (City, town, or county) (State) <i>Balto. Md.</i>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>MAR 23 1970</i>				<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor, M.D.</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Leonard J. Ruck Inc. Bal to. Md.</i>	

above

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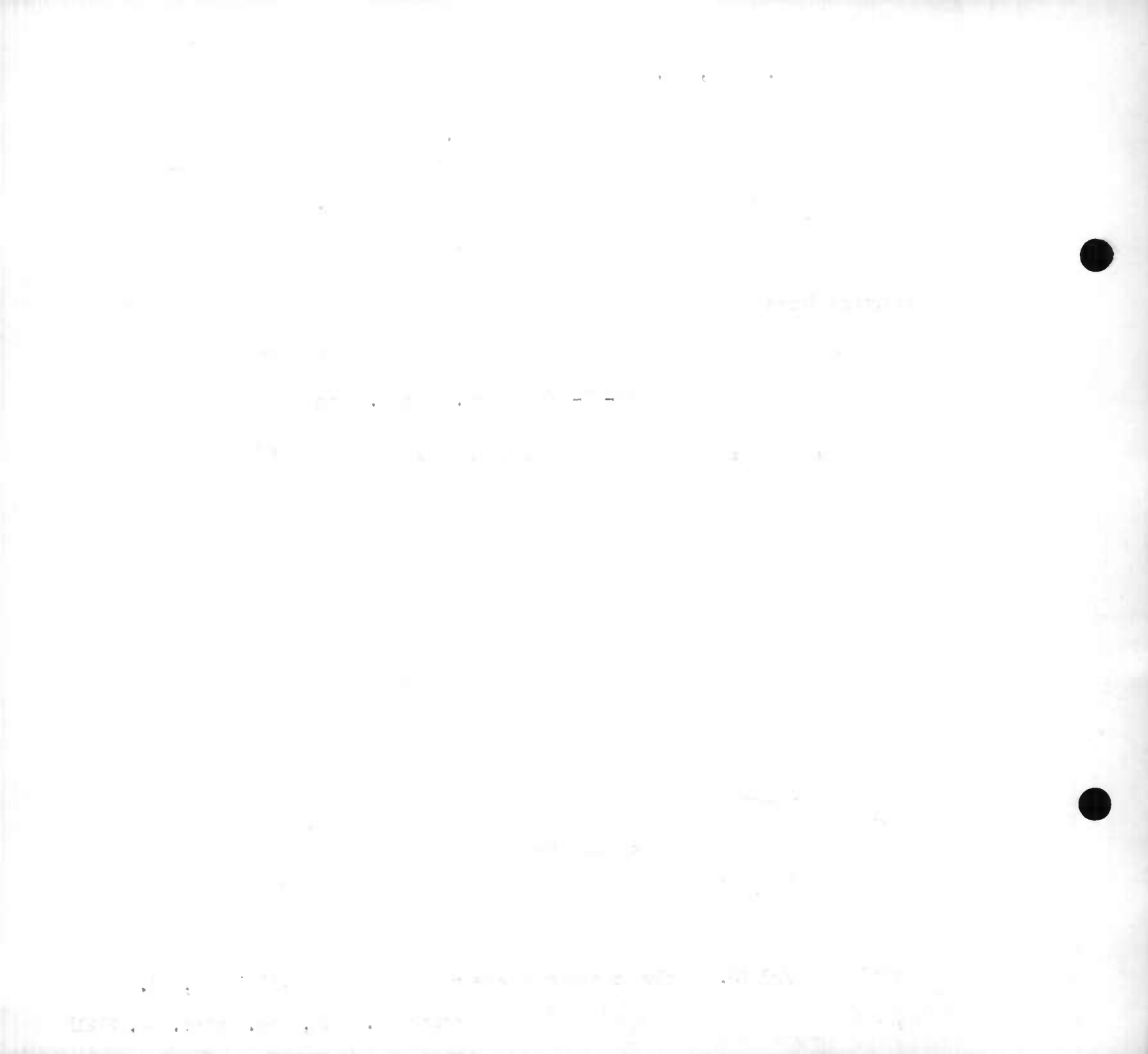
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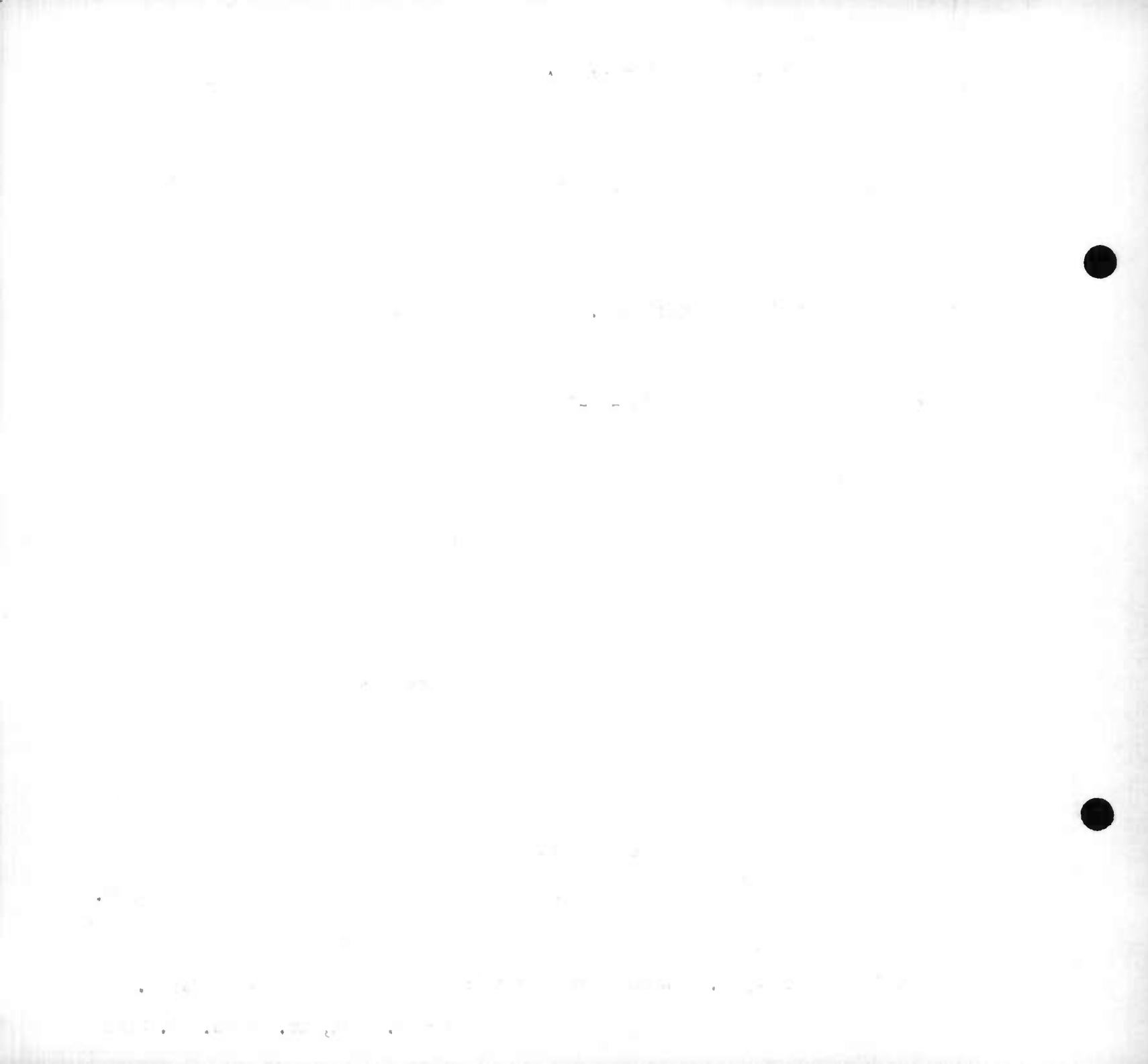
R-508 70 3027		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Harry M. Ryan, Sr.		2. DATE AND HOUR OF DEATH 3-17-70 2:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 901 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 932 Argonne Dr.	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years lost birthday) 57
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ryan		14. MOTHER'S MAIDEN NAME Catherine VonDorn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215003-8470	17. INFORMANT Mrs. Anna M. Ryan ADDRESS (Same)
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 6 hrs 5 yrs	
19A. DATE OF OPERATION 2/27		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (A) (this hospital) attended the deceased from 3/19 19 70 to 3/19 19 70 that (I) (we) last saw the deceased alive on 3/19 19 70 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Richard A. Baum, M.D.		23B. DATE SIGNED 3/19/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/23/70	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

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C-625 70 3028		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3028	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) (George Gates Carson, Sr.)		2. DATE AND HOUR OF DEATH			
		Gates George Carson, Sr.		19-March-70 8 <sup>12</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. BALTO. CO.		5300			
South Baltimore Gen. Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		Baltimore					
		E. STREET AND NUMBER		7838 St. Fabian Lane		21222	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-29-18	51	Chauffeur	Transit Co.	Pennsylvania
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
						USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Harry Carson		Edna Lutzel		No		160-16-1701	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
Wife - Doreen Carson - Same							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		Cardiogenic Shock		- 2 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Myocardial Infarction		3 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		ASCVD			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 18-March 1970 to 19-March 1970		that (I) (we) last saw the deceased alive on 19-March 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Richard E. Fisher M.D.		3/19/70.		Richard E. Fisher M.D.		South Balt. Gen. Hosp. 1	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State)	
Burial		3/24/70.		Center County Memorial Park		State College, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 23 1970		Robert E. Fisher, Jr.		Leonard J. Ruck, Inc.		Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3029</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">(Robert L.)</span> <span style="font-size: 1.2em;">Baby Boy Mehling, Jr.</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3-18-70</span> <span style="float: right;">11:40 p.m.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		<b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>6. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>7. FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">37 Mercy Hospital</span>		<b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2464 Ellis Rd.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">3-18-70</span>	<b>9. AGE</b> In years (last birthday) <span style="font-size: 1.2em;">5</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Robert Mehling, Sr.</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">XXXXXXXXXX Joann E. Burger</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">None</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Robert L. Mehling</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">(Same)</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">Hyaline Membrane Disease</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Prematurity</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Severe Erythroblastosis Fetalis</span> (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">at birth</span>
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.5em;">Abruptio Placenta</span>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">March 18 1970</span> <b>to</b> <span style="font-size: 1.2em;">March 18 1970</span> <b>that (I) (we) lost saw the deceased alive on</b> <span style="font-size: 1.2em;">same</span> <b>19</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Arturo Q. Santos, MD</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">March 14, 1970</span>		<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">ARTURO Q. SANTOS, MD</span>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/20/70.</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 23 1970</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, R.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>		

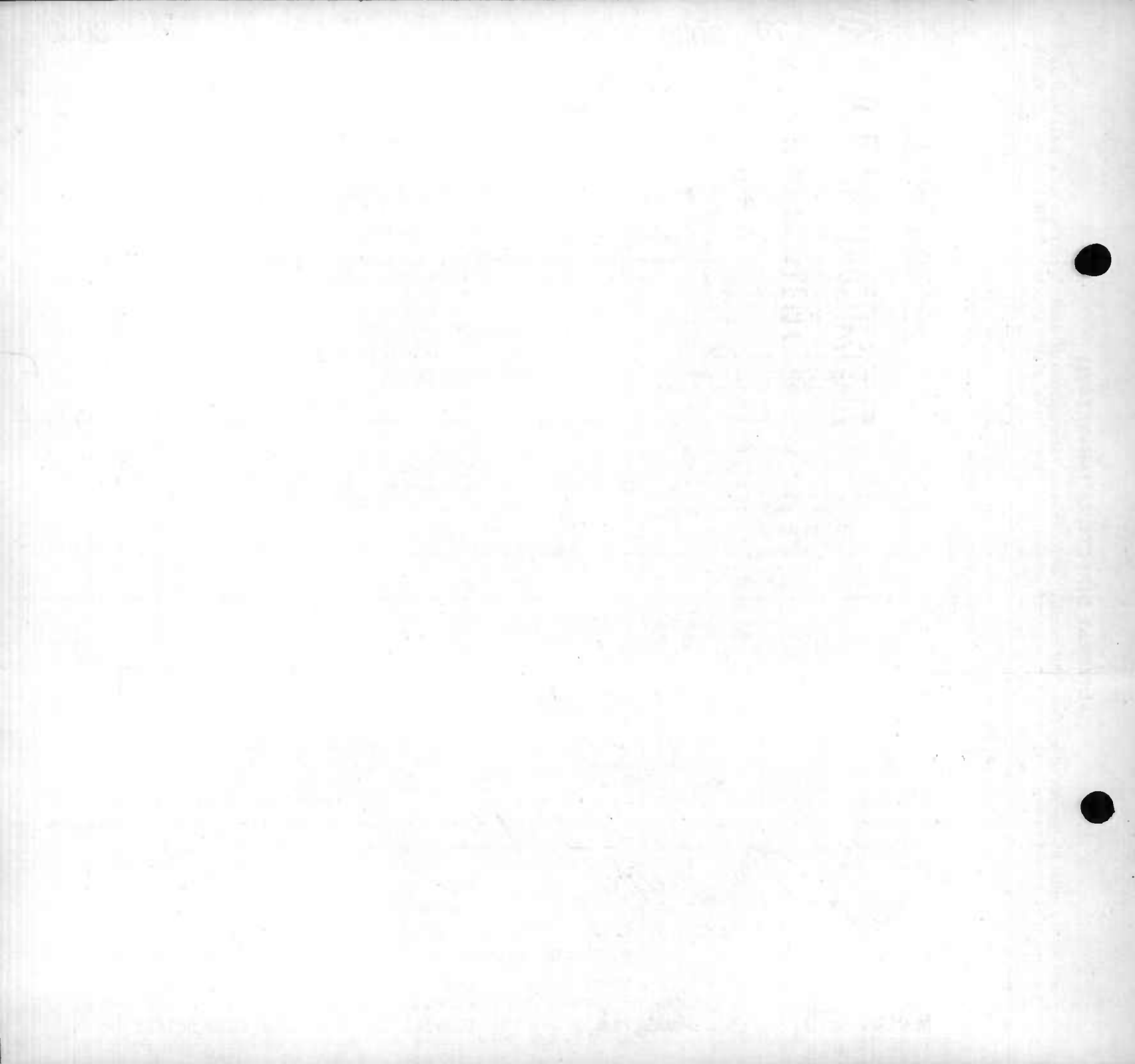




FUNERAL DIRECTOR: IMPORTANT

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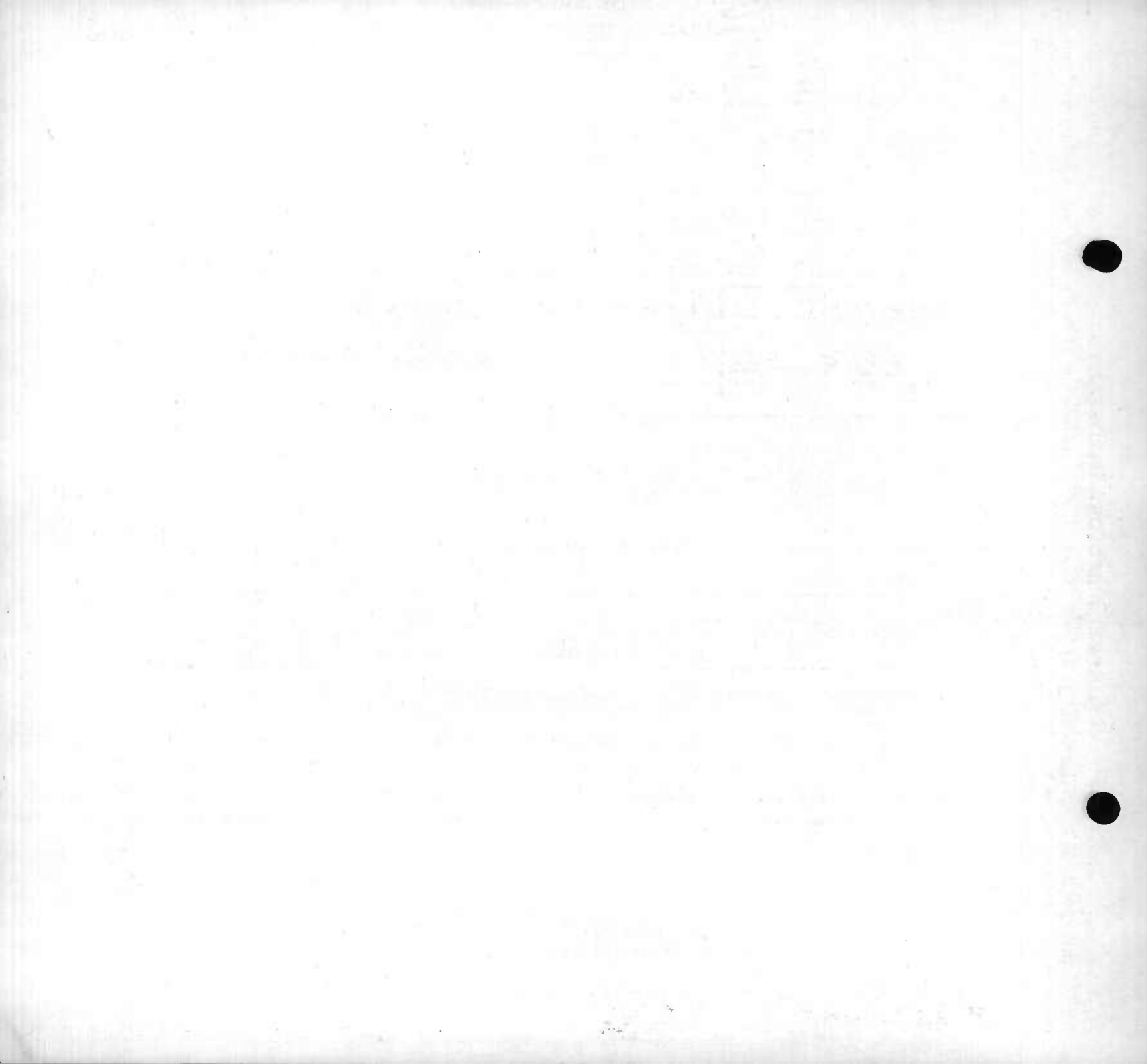
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3030</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">M-452 70 3030</span> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> </div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HARRY R. MULLINIX			March 16, 1970 <span style="float: right;">8:30 A. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em;">90</div> Hood Nursing Home 5315 Edmondson Ave.,			A. STATE		B. COUNTY
			Maryland		Baltimore
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			528 Academy Road		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 2, 1884	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Painter-retired			Painting		Maryland
					U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William R. Mullinix			Susan Dailey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			218-14-1445		Mrs. Grace Mullinix, 528 Academy Road.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			Other acute cardiac disease Disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to March 16, 1970, that (I) (we) lost saw the deceased alive on March 14, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				3/17/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. Nelson McKay, M.D.				6014 Edmondson Ave.,	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/19/70		Howard Chapel Cemetery	
				Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 23 1970		Robert E. Taylor, Jr.		Ulrich Funeral Home 4210 Belair Road.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3031</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">E-420 70 3031</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Ellis, Isabella</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3-14-70 4:55 P. M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">LAKE Drive Convalescent Center 2401 Eutan Place 90</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">1301</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2401 Eutan Place</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Fe</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12/21/1881</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">88 yrs</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SEAMSTRESS</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">GOODWILL STORES</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">LUKE ELLIS</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MINNA MEYERS</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-54-1785</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Myrtle Strand (Niece)</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">4019 Park Side Dr. Baltimore</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARDIAC ARREST</span> (B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">AS EVD</span> (C)		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">12/17/68</span> <b>19</b> <span style="font-size: 1.2em;">3/14</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">3/10</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">In Belman</span> <span style="font-size: 1.2em;">MD</span> <span style="font-size: 0.8em;">DEGREE</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/15/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MARCELINO F. ALBUERNE</span> <span style="font-size: 1.2em;">MD</span> <span style="font-size: 0.8em;">DEGREE</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">7935 PIPERS PATH SLEN BORNIE M D</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/24/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">LOUDON PARK</span>	
<b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">BALTIMORE MD.</span>		<b>24E. (State)</b> <span style="font-size: 1.2em;">21061</span>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 23 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">William F. Home</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">4210 Belman</span>	



1  
H-243  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 70 3032

1. NAME OF DECEASED (Type or Print) <b>RENA HAZLETT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 19, 1970</b>		Hour <b>1:30 A.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 19, 1970</b>		Hour <b>1:30 A.</b>
6. SEX <b>Female</b>		7. RACE <b>White</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>June 20, 1950</b>		10. AGE (In years last birthday) <b>19</b>		E. STREET AND NUMBER <b>324 Broad Street</b>
11. BIRTHPLACE (State or foreign country) <b>Maine</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>William Albert</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Margret Martin</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Margaret Albert, Meriden, Conn.</b>
19. CAUSE OF DEATH <b>E812.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Craneo-cerebral injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Craneo-cerebral injuries</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>#695 - 1/4 mile N. of #372 (Wilkins Ave.)</b>
22D. TIME OF INJURY (APPROX.) <b>3-18-70 3:05 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-truck collision</b>
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate, M.D.</b> EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>March 19, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart,</b>
24D. LOCATION (City, town, or county) (State) <b>Meriden, Conn.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home Baltimore, Md. for J.J. Ferry &amp; Sons. Meriden, Conn.</b>		

4.0

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-325		70 3033		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3033	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>GUDGEON, DAISY</i>				2. DATE AND HOUR OF DEATH <i>3/15/70 1:30 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore Co</i>		<i>5300</i>	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <i>7303 Hughes Avenue 21219</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-30-94</i>		9. AGE (In years last birthday) <i>76</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Robert Councilman</i>				14. MOTHER'S MAIDEN NAME <i>Louise</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH Records - Baltimore, Maryland 21224</i>					
18. <i>4-36-91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>myocardial infarction</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>20 days</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Initially medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>3/15/70</i> 19 to <i>3/15/70</i> 19 that (1) (we) last saw the deceased alive on <i>3/15/70</i> 19 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J.R. Wands M.D.</i>				23B. DATE SIGNED <i>3/15/70</i>		23C. PHYSICIAN'S NAME (Type) <i>J.R. Wands, M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/18/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Colgate, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Ullrich Funeral Home Dundalk, Md.</i>		ADDRESS			

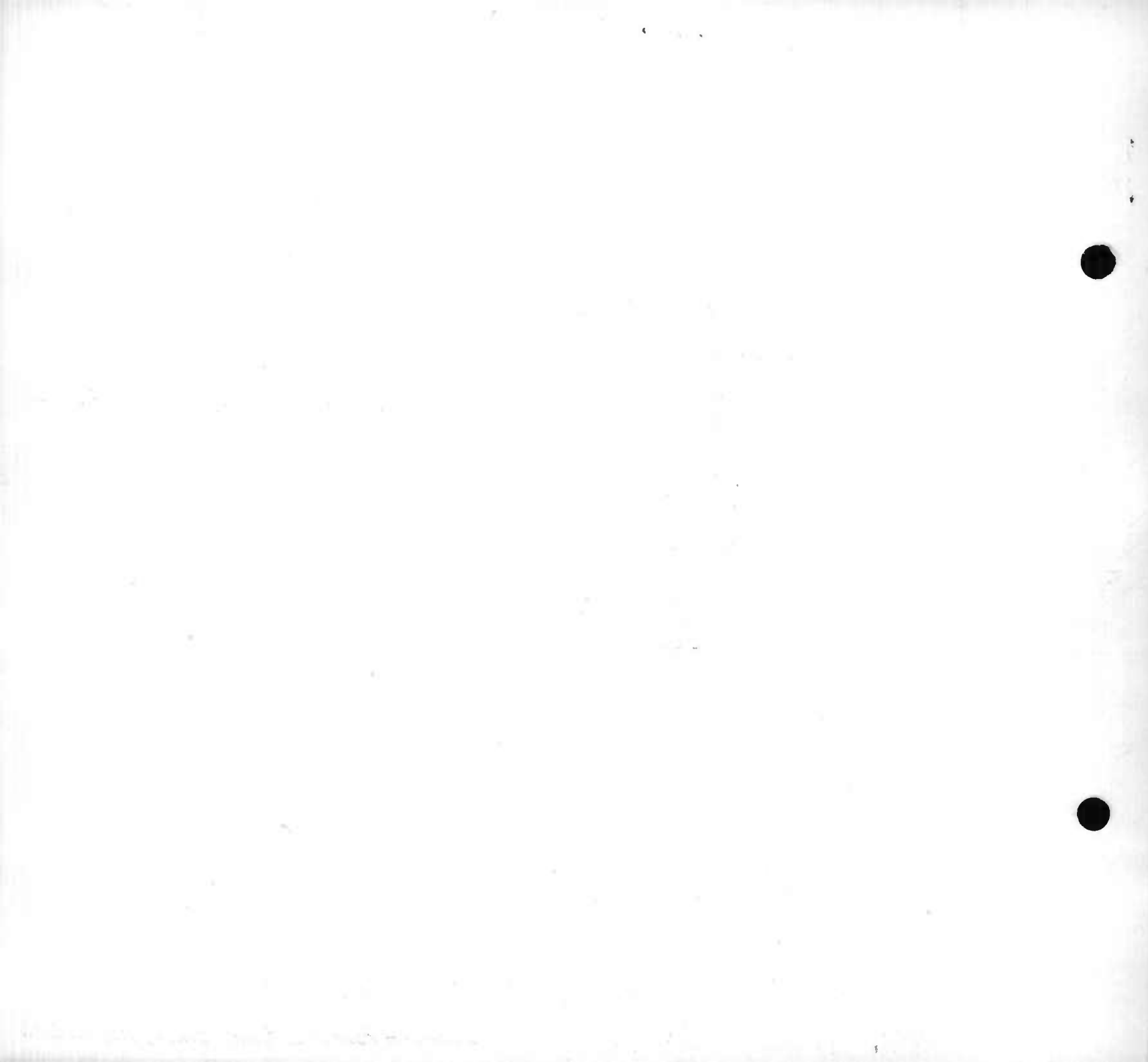




# **FUNERAL DIRECTOR: IMPORTANT**

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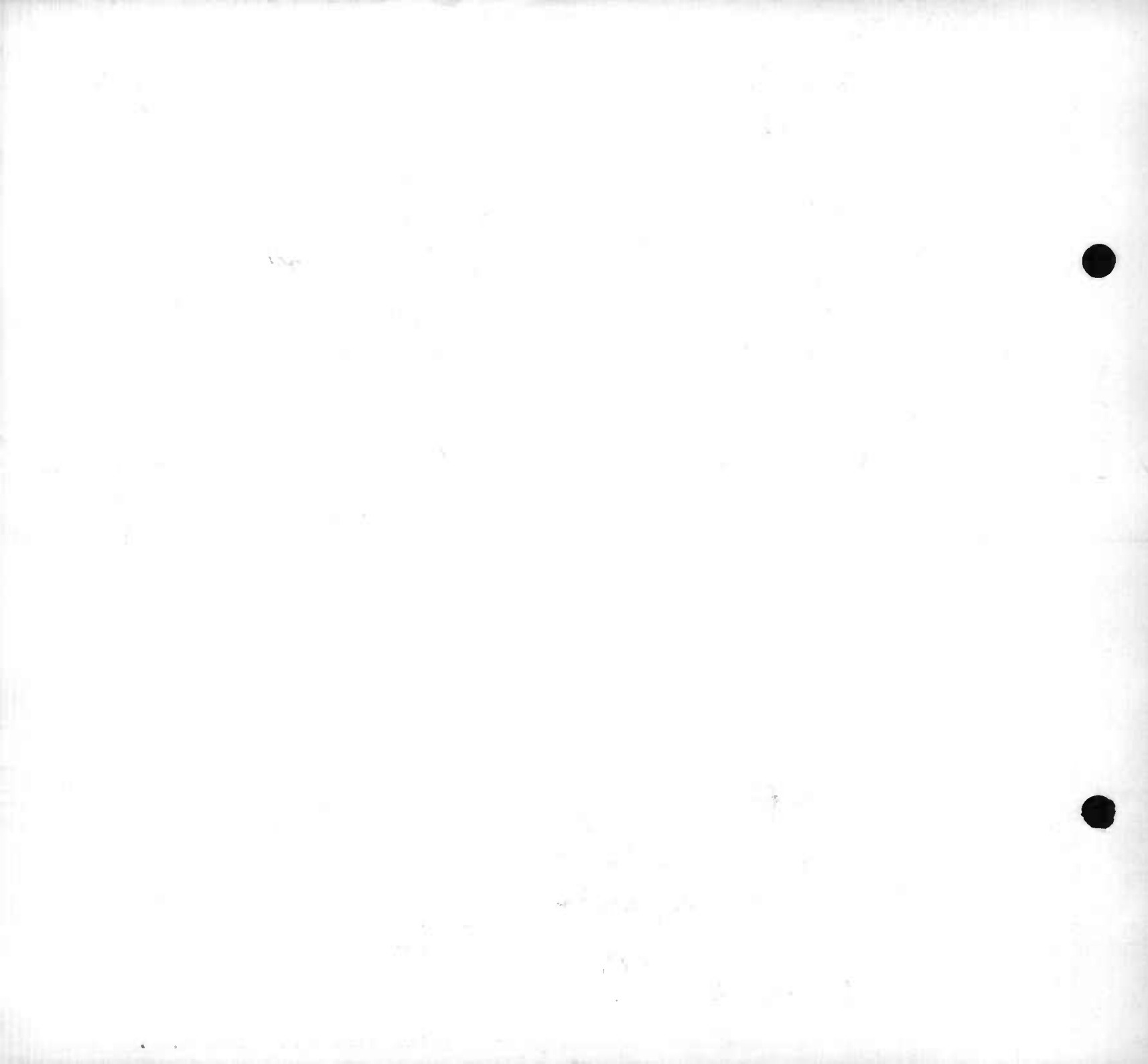
X-560 70 3034		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3034	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RENNER, CONRAD</b>		2. DATE AND HOUR OF DEATH <b>MARCH 17<sup>th</sup> 1970, 12-45A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO CO</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		E. STREET AND NUMBER <b>7811 Ardmore Ave</b>		F. CITY OR TOWN <b>BALTIMORE</b> G. STATE <b>MD</b> H. ZIP CODE <b>21218</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/1985</b>	9. AGE (in years last birthday) <b>84 y</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ELEC. MFG.</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>John RENNER</b>		14. MOTHER'S MAIDEN NAME <b>Katharina Vogel</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>- 01</b>		17. INFORMANT <b>JOAN M. RENNER 7811 ARDMORE AVE. 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>434.91-2-01</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Heart</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Heart</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19A. DATE OF OPERATION <b>3/11/1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Heart</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>7811 Ardmore Ave 21218</b>	
21D. TIME OF INJURY (APPROX) <b>Oct 28, 70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fall</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>28 Oct 19 70</b> to <b>17 Mar 19 70</b> that (I) (we) last saw the deceased alive on <b>17 Mar 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank J. Geller, MD</b>		23B. DATE SIGNED <b>Mar 17, 70</b>		23C. PHYSICIAN'S NAME (Type) <b>Frank J. Geller, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>20 MAR 70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>ULRICH FUNERAL HOMES BALTO, MD 21206</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-656 70 3035		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3035	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>James Warner</u>		2. DATE AND HOUR OF DEATH <u>11 55 AM 3/12/70</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard County</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		C. CITY OR TOWN <u>Laurel</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>Rt #1 Box 147</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/93</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>George L Warner</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Holland</u>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virginia Back, Laurel Md</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Obstructive Pulmonary Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cor Pulmonale</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Probable Carcinoma of Head &amp; Pancreas</u>		<u>5 years</u>	
(C) <u>6 mos</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/12/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>3/10</u> 19 <u>70</u> to <u>3/12</u> 19 <u>70</u> and that (I) ( <del>we</del> ) last saw the deceased alive on <u>3/12</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Richard Baum, M.D.</u>		23B. DATE SIGNED <u>3/12/70</u>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS <u>University of Maryland Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/15/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>	
24D. LOCATION <u>Seabrookville Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelley, R.D.</u>		25C. FUNERAL DIRECTOR <u>Dawitt Donaldson, Laurel, Md.</u>	



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BALTIMORE CITY HEALTH DEPARTMENT		70 3036		70 3036	
BIRTH NO.		70 3036		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>MARY E. KANE</b>		2. DATE AND HOUR OF DEATH <b>3-21-70 11:05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>301</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME &amp; HOSPITAL</b> <b>100 N. BROADWAY, Baltimore</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-00</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>WILLIAM McKEY</b>		14. MOTHER'S MAIDEN NAME <b>ROSE STENCY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-22-5363</b>		17. INFORMANT <b>PATIENT</b>	
18. <b>530.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PNEUMONIA WITH OBSTRUCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Mos</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>LOWER ESOPHAGEAL STRICTURE</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>YRS 1963?</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>SEVERE ANEMIA</b>					
19A. DATE OF OPERATION <b>FEB. 3, 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STRICTURE = GASTROSTOMY</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-3-70</b> to <b>3-21-70</b> and that (I) (we) last saw the deceased alive on <b>3-21-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ricardo M. Truason MD</b>		23B. DATE SIGNED <b>3-21-70</b>		23C. PHYSICIAN'S NAME (Type) <b>RICARDO M. TRUASON MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Lilly &amp; Zeiler Inc.</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		25D. ADDRESS <b>1901-07 Eastern Ave.</b>			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70</span> <span style="font-size: 1.5em;">3037</span>
BIRTH NO. <span style="font-size: 1.5em;">B-656</span> <span style="font-size: 1.5em;">3037</span>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LILLIAN BERNHARDT</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/21/70</span> <span style="font-size: 1.2em;">5:25 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Church Home and Hospital</span>		A. STATE <span style="font-size: 1.2em;">M.D.</span> B. COUNTY <span style="font-size: 1.2em;">201</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">Saltimore</span> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <span style="font-size: 1.2em;">2205. Chapel Street</span>				
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12-9-94</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">75 yrs</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Home Life</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">America</span>				
13. FATHER'S NAME <span style="font-size: 1.2em;">John Zebroski</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-03-4597</span>		17. INFORMANT <span style="font-size: 1.2em;">Daughter Lucille Fratanuono</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">5-24-91</span> <b>CAUSE OF DEATH</b> <span style="font-size: 1.2em;">Cardiac Arrest</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">3-19-70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Stones in Gallbladder</span>		19C. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-12-</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/21/</span> 19 <span style="font-size: 1.2em;">70</span> that (I) <del>was</del> last saw the deceased alive on <span style="font-size: 1.2em;">3/21/70</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> <del>did not</del> view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">T. L. Lillian</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">March 21, 1970</span>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <span style="font-size: 1.2em;">Church Home &amp; Hospital</span>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <span style="font-size: 1.2em;">3-24-1970</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Oak Lawn</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore County, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 23 1970</span>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</span>





M-324

70

3038

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3038

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WAYNE METCALF</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME AND HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 12:30 P.M.</b>	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <b>4.7.20</b>		10. AGE (In years lost birthday) 49	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roscoe Metcalf</b>		14. MOTHER'S MAIDEN NAME <b>Eva Metcalf</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>244-163179</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of liver OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/22/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/28/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Hope Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Mount Hope N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>John R. [unclear]</b>	
25C. FUNERAL DIRECTOR <b>William L. [unclear]</b>		ADDRESS <b>2342 W. North Ave. Baltimore</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3039</span>	
B-630 70 3039		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ETTA BARRETT</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/22/70</span>   <span style="font-size: 1.2em;">7:00 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">42S, NAH HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALT.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALT.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2103 LYN HURST AVE</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/19/07</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">62</span>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Hickory, N. Carolina</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Unk.</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unk.</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-26-4280A</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">21202</span> <span style="font-size: 1.2em;">Mrs. Annie Mae Whitten 1820 Guilford Ave.</span>		
18. <span style="font-size: 1.2em;">23091</span> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">ASCVD</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 days</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAR 19</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">MAR 22</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAR 21</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Victor Borden MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">3/22/70</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">VICTOR BORDEN MD</span>			23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3-26-70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Auburn</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 23 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">D. E. E. Jones, MD</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">1735 Harford Ave. 21043 Marshall W. Jones, Jr.</span>			

17-4-77

17-4-77

17-4-77

1

W-600 70 3040 BALTIMORE CITY HEALTH DEPARTMENT 70 3040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BARBARA A. WARE

2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☐ M.

3. DATE OF PRONOUNCED DEAD Month Day Year Hour March 21, 1970 4:50 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) 46 LUTHERAN HOSPITAL 3-26-70

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1511

6. SEX Female 7. RACE Male Negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH Oct 21-1941 10. AGE (In years last birthday) 28 11. BIRTHPLACE (State or foreign country) Balto. Md. 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME Robert Ware

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME Clarence Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 17. SOCIAL SECURITY NO. 21242-1544 18. INFORMANT ADDRESS Clarence S. Ware 3306 Liberty Heights Ave

19. CAUSE OF DEATH Multiple traumatic injuries DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3306 Liberty Heights Avenue - West of Hilton Street 15-11

22D. TIME OF INJURY (APPROX.) 3-21-70 2:10 A. M. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Pedestrian struck by car

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 3/21/70

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/21/70 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem Balto Md 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR ADDRESS Earl Gilmore 1827 W. North Ave

Oct 21-1941  
Dear Mr.  
Mumford  
no

Dear Mr.  
Mumford  
no

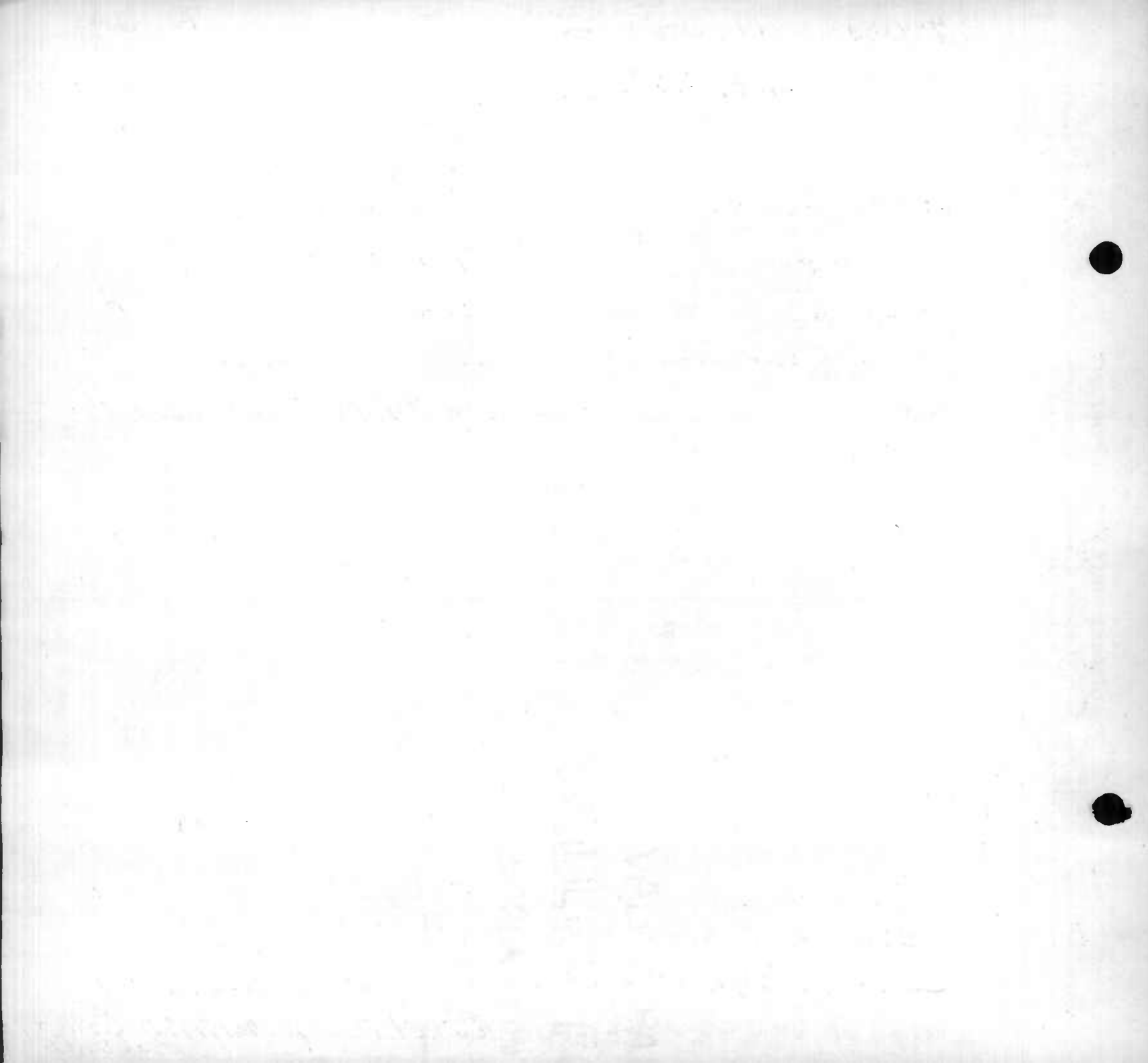
Dear Mr. Mumford  
no

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 70 3041				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3041	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BERTHA E. HILL</b>				2. DATE AND HOUR OF DEATH <b>3/22/70 12:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>2710</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>609 Radnor Ave.</b>				C. CITY OR TOWN <b>Belts.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>609 Radnor Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/13/1885</b>		9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>idone</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Jarrett Walton</b>				14. MOTHER'S MAIDEN NAME <b>angelina carding</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Margaret L. Hill</b>		ADDRESS <b>609 Radnor Ave</b>	
18. <b>44091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Dehydration</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Uremia</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>6 weeks</b>	
				(C) <b>Arteriosclerosis Sclerosis</b>		<b>10 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Conjunctive Heart Failure</b>						<b>5 yrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov 19 69</b> to <b>March 22 19 70</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 19 19 70</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Alan B Cohen</b>				DEGREE Attending <input checked="" type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/22/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN B. COHEN</b>				23D. ADDRESS <b>3501 ST Paul ST</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>md</b>		24B. DATE <b>3/26/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Lukes</b>		24D. LOCATION (City, town, or county) (State) <b>Belts. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Alvin S. Chaturvedi</b>		ADDRESS <b>1201 McCallum St. Balt. Md.</b>	







S-312

70 3042 CERTIFICATE OF DEATH

REG. NO. 70 3042

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Howard Stoops		3/18/70 9:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21222				Maryland Baltimore 5300	
5. SEX		6. RACE		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male		White		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER	
				3117 Sollers Point Road 21222	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
1-1-1878		92		X84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Farmer retired				Maryland	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Webster Stoops				Ida M. Maslin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/1/70 to 3/18/70, that (I) (we) last saw the deceased alive on 3/1/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William MacDonald M.D.				3/18/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
William MacDonald				4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/21/70		St. Paul Cemetery near Chestertown, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 23 1970		J. E. Wells		J. E. Wells Chestertown, Md.	

Released by Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT

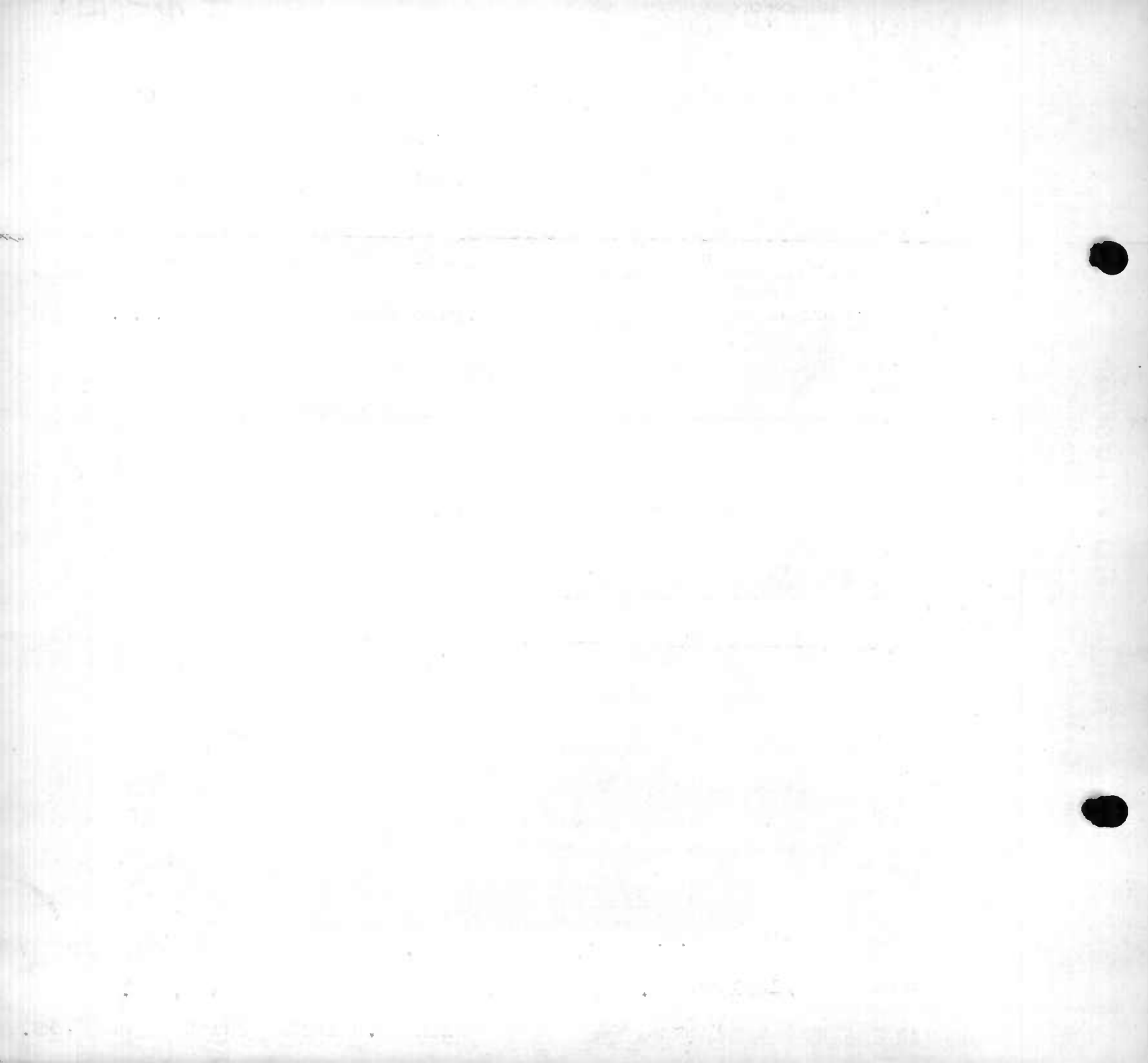
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
D-600 70 3043					70 3043				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) <b>Henry Duer</b>					2. DATE AND HOUR OF DEATH <b>3-13-70 - 3<sup>30</sup>pm</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1307</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Keswick</b>					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <b>700 W. 40th ST</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-12-73</b>	9. AGE (In years last birthday) <b>96</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Investment broker</b>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Somerset County</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>Edward Duer</b>				
14. MOTHER'S MAIDEN NAME <b>Virginia White</b>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.					17. INFORMANT <b>Medical Records-Keswick</b>				
18. <b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis</b>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
19. ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>31 Aug 1964</b> to <b>13 Mar 1970</b> , that (I) (we) last saw the deceased alive on <b>13 Mar 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Aubrey J. Richardson M.D.</b>								23B. DATE SIGNED <b>13 Mar 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Aubrey Richardson M.D.</b>								23D. ADDRESS <b>700 W. 40th Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>3/16/1970</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. ANDREW CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MD.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>REYNOLD WILSON PRINCESS ANNE, MD.</b>			



1

L-532

70

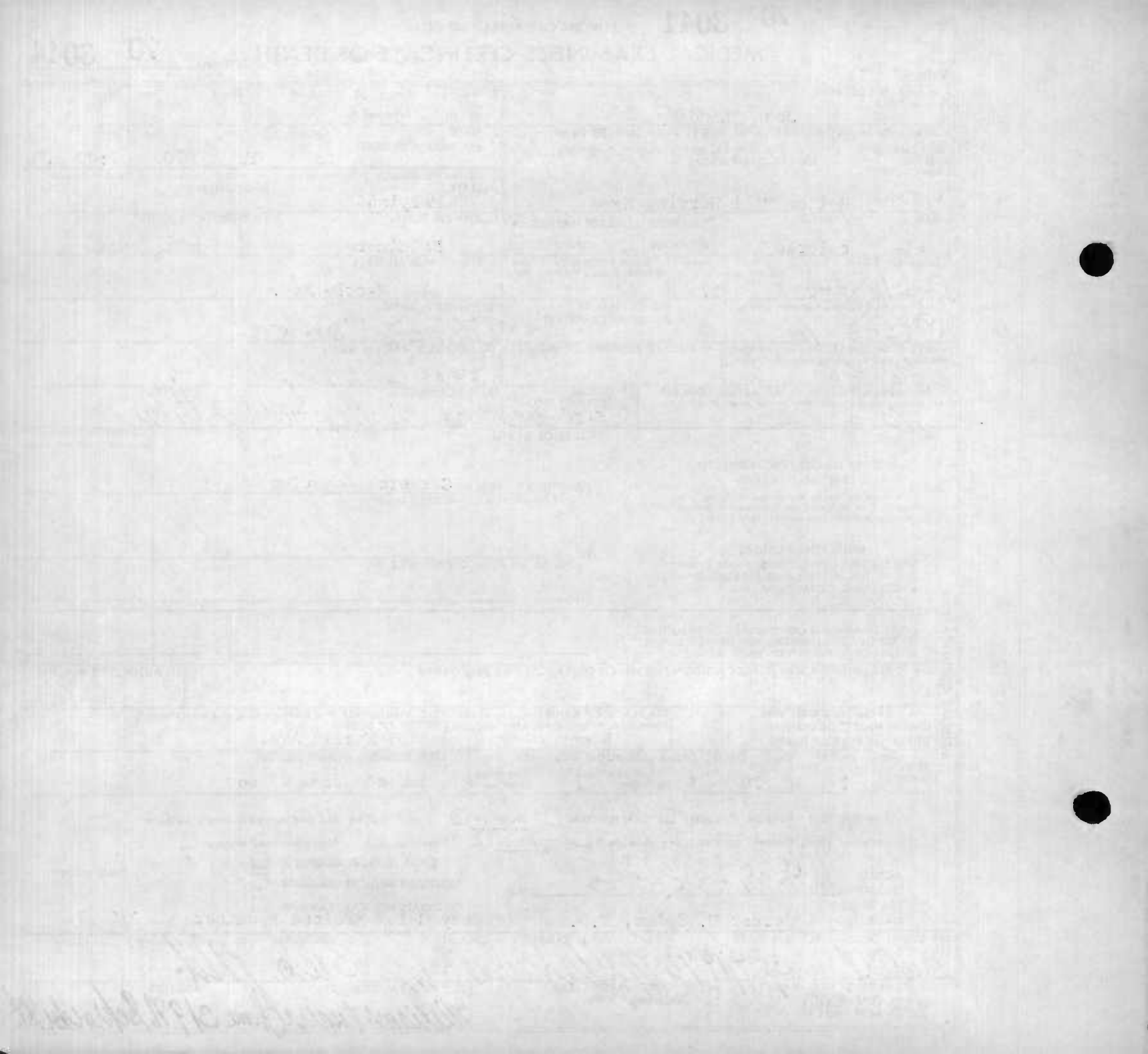
3044

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3044

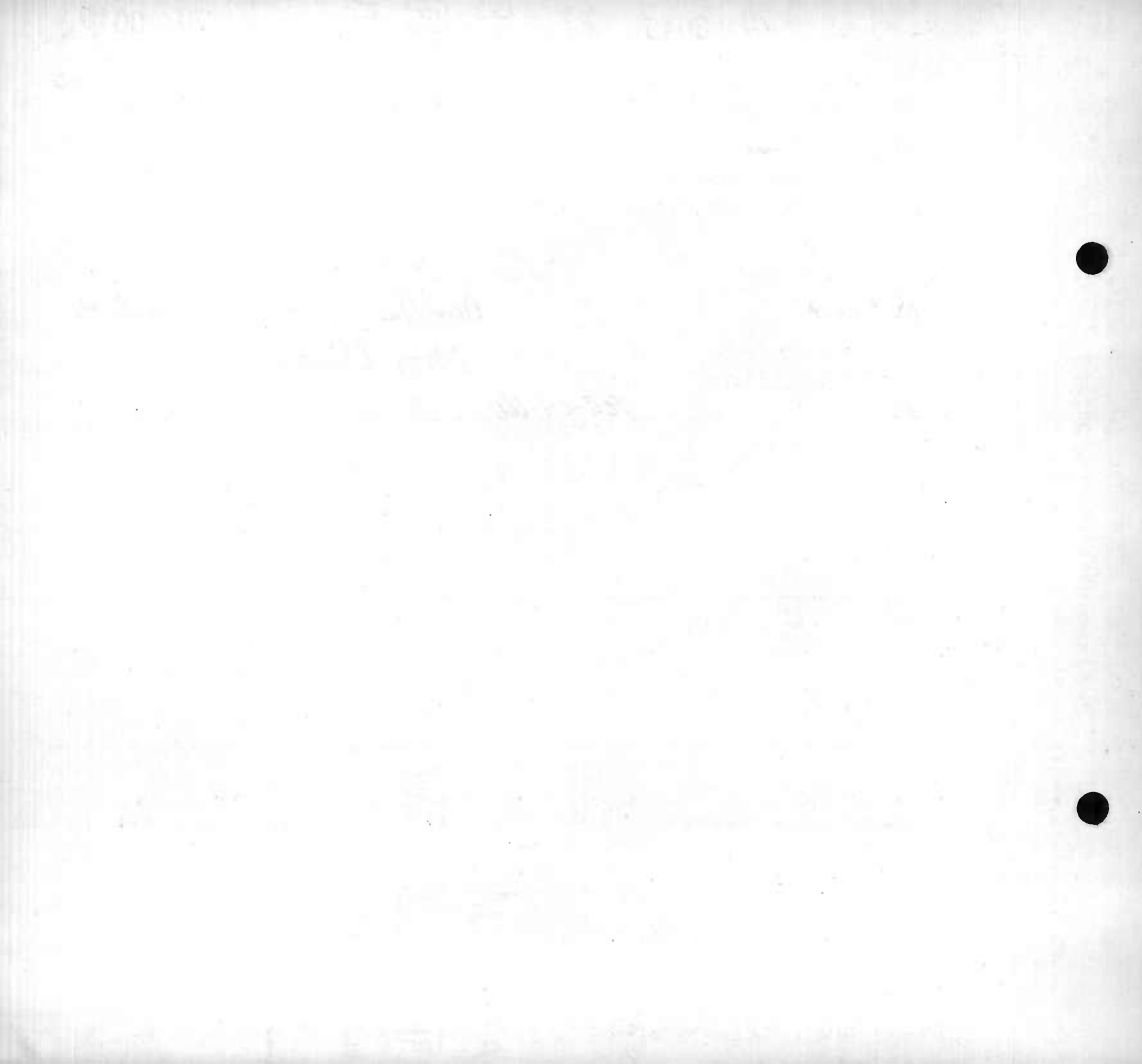
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John Lindsey</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing Home</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 19 70 5:00 p. M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>	
6. SEX <b>male</b>	7. RACE <b>colored</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Dec. 16, 1942</b>		10. AGE (in years last birthday) <b>27</b>		E. STREET AND NUMBER <b>1409 Myrtle Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Sacks Va.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>James Cook</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Rosa Lindsey</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-70-9600</b>		18. INFORMANT ADDRESS <b>Rosa Lindsey 1409 Myrtle Ave.</b>	
19. <b>E951X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebral injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1409 Myrtle Ave. 1402</b>	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) <b>2 18 70 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>jumped from window</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <b>3/20/70</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cem. Balto. Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Schroeder St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-420 70 3045				BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3045	
1. NAME OF DECEASED (Type or Print) <b>ROBERT L. COLES</b>				2. DATE AND HOUR OF DEATH <b>MARCH 14, 1970 14:20 M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON STR., BALTO., MD. 21216</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>600 N. Arlington Ave</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 26 1904</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Danville Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Coles</b>				14. MOTHER'S MAIDEN NAME <b>Mary Guess</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-09-6611</b>		17. INFORMANT <b>Mrs. Katherine Coles</b>		ADDRESS <b>600 N. Arlington Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>ACIDOSIS CARCINOMA OF THE PANCREAS METASTASES IN LIVER &amp; LUNG.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that <del>X</del> (this hospital) attended the deceased from <b>MARCH 5</b> , 1970 to <b>MARCH 14</b> , 1970, that <del>X</del> (we) last saw the deceased alive on <b>MARCH 14</b> , 1970 and that in <del>X</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>X</del> (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Christos Dibranos, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED _____	
23C. PHYSICIAN'S NAME (Type) <b>CHRISTOS DIBRANOS, M.D.</b>				23D. ADDRESS <b>730 ASHBURTON STR., BALTO., MD. 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-19-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph R. Guess</b>			
				ADDRESS <b>2222 N. North Ave</b>			





1  
T-520 70 3046 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3046

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOUGLAS M. B. THOMAS A. K. DOUGLAS THOMAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 14 70 1:55 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 14, 1970 1:55 a.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Maryland B. COUNTY 1503	
9. DATE OF BIRTH Feb. 6, 1942		10. AGE (In years lost birthday) 28	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		14B. KIND OF BUSINESS OR INDUSTRY Hosp.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 214-38-5058	
18. INFORMANT Mr. James Thomas		ADDRESS 1720 N. Warwick Ave.	

19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive bilateral pulmonary embolism	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Isidore Mihelakis* M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Isidore Mihelakis, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 3/14/70

ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-70		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery Baltimore		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970		25B. NAME OF REGISTRAR Robert E. Tubey, M.D.		25C. FUNERAL DIRECTOR Joseph L. Jones		ADDRESS 2222 W. North Ave.	

Printed

March 3-17-70

April 1st 1870

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-362 70 3047		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 616 3047	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WATERS William</u>		2. DATE AND HOUR OF DEATH <u>3-22-70</u> <u>11 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		M. <u>301</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1213 LIGHT ST Baltimore Md</u>		F. STREET AND NUMBER <u>207 South Bond ST.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1900</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Moses Waters</u>		14. MOTHER'S MAIDEN NAME <u>SMITH</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-20-2034</u>		17. INFORMANT <u>Jeannette Waters Belair</u> ADDRESS <u>Md.</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hypertension C &amp; D disease</u> years DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerosis generalized</u> years DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> 19 <u>70</u> to <u>3/22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALAN H. MACHT</u>		23B. DATE SIGNED <u>3/22/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>	
23D. ADDRESS <u>2 E. Bond St Baltimore Md</u>		23E. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>		23F. ADDRESS <u>2 E. Bond St Baltimore Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	
24D. LOCATION (City, town, or county) (State) <u>Harford Bel Air Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Robert E. W. Tittle Bel Air Md</u>		24H. ADDRESS <u>Bel Air Md</u>		24I. ADDRESS <u>Bel Air Md</u>	

1912-1913  
1912-1913

0

1912-1913

1912-1913

1912-1913

G-450

70

3048

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3048

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LILLIAN Pauline Gilliam

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 20, 1970

4:30 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1510

6. SEX

Female

7. RACE

Negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-24-31

10. AGE (In years)

38

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3838 Boarman Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Gross

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ruth Burley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Robt. Gilliam 1119 Fulton Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Cirrhosis of Liver

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/21/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3-25-70

24C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1970

25B. NAME OF REGISTRAR

Robert E. Barber, M.D.

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

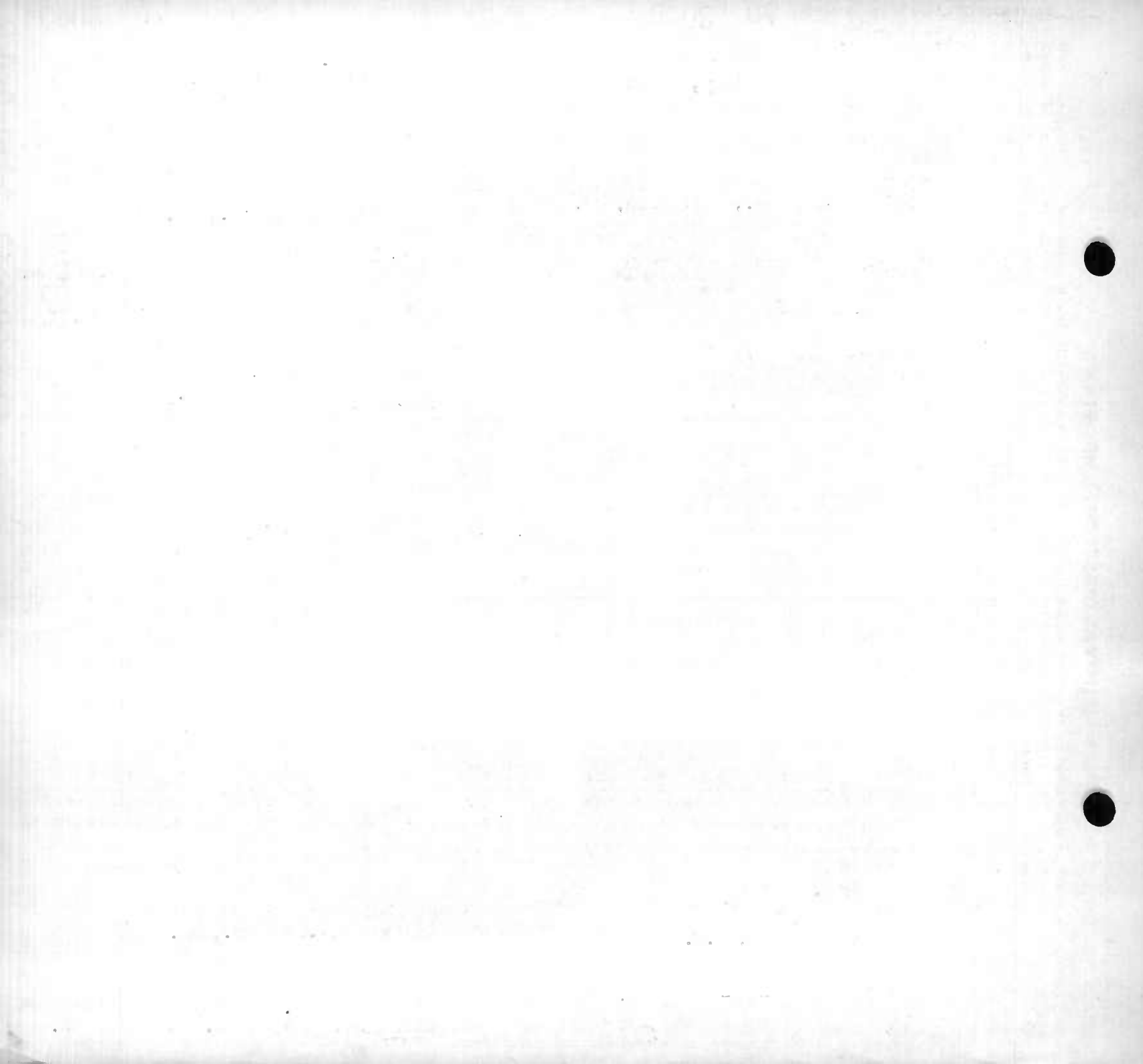
Kelson F.H. 1348 Calhoun Street

WALLACE & GORDON

1007 N. 1st St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-500 70 3049				70 3049	
BIRTH NO. CONWAY, INEZ				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Conway, Inez			2. DATE AND HOUR OF DEATH MARCH 20, 1970 11 <sup>20</sup> P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224			Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2900 Fisk Rd. Balto., Md. 21225		
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-13	9. AGE (In years last birthday) 56 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) V.A.		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME HARRISON Butts			14. MOTHER'S MAIDEN NAME Ella Blackwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Edna Taylor-3103 Normount			18. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 BCH Records:		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9 <sup>00</sup> AM Mar. 20 1970 to 11 <sup>20</sup> PM Mar 20 1970, that (I) (we) last saw the deceased alive on 11 <sup>20</sup> PM 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sun Chul Kim, M.D.			23B. DATE SIGNED 3/20/70		23C. PHYSICIAN'S NAME (Type) Sun Chul Kim, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-25-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery
24D. LOCATION Baltimore, Maryland			24E. ADDRESS 4940 Eastern Ave., Balto., Md. 21224		
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970			25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 1348 N. Calhoun St.





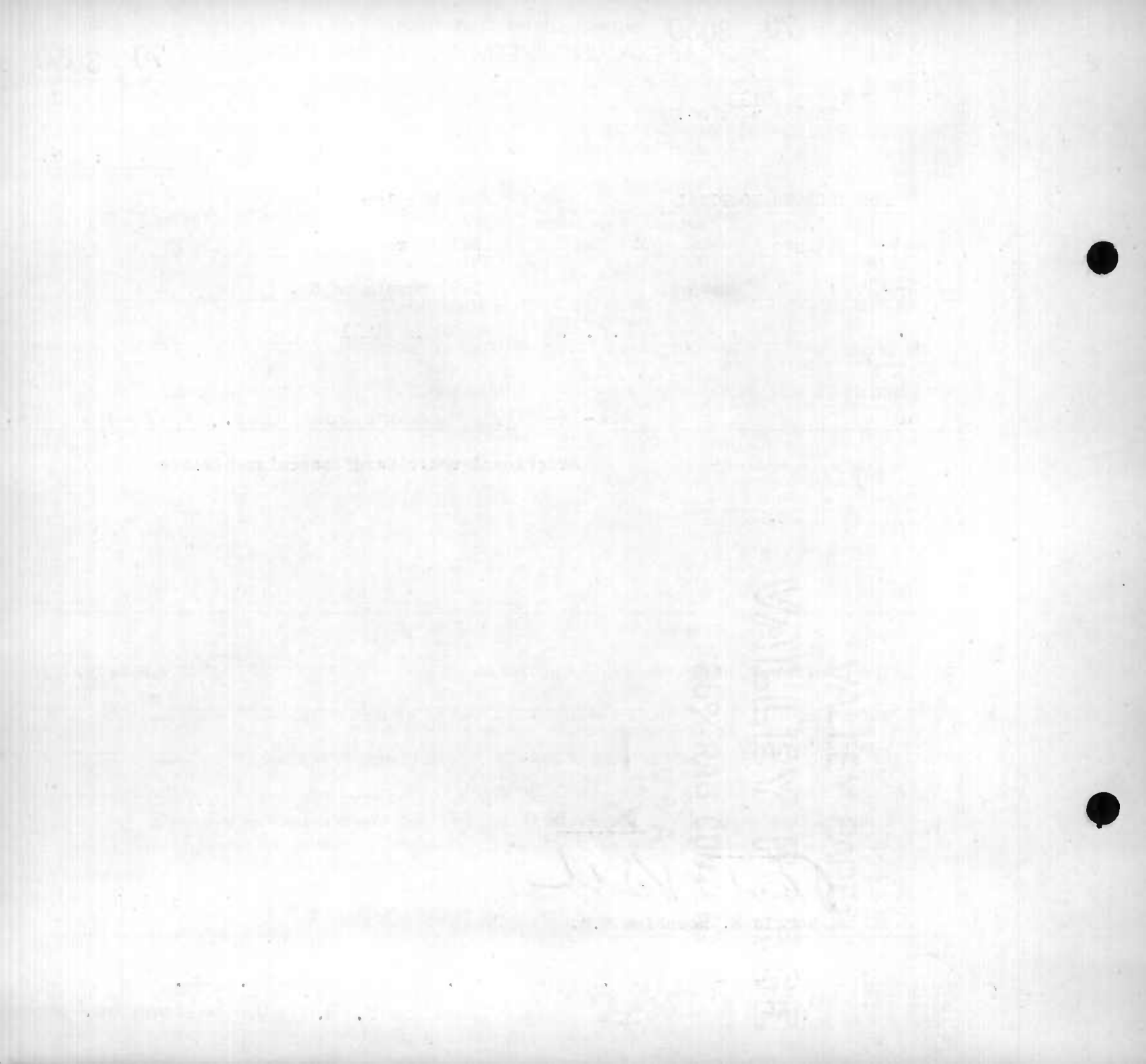
1

M-263 70 3050 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3050

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Hill BERTHA McCARTER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 BON SECOURS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 8:05 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-5-05</b>		10. AGE (In years last birthday) <b>65</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214-18-0639</b>	
18. INFORMANT <b>Theodore Rose (nep.)</b>		ADDRESS <b>1917 North Ave.</b>	
19. <b>712.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Kelson E. H.</b>	
25C. FUNERAL DIRECTOR V. <b>1348 Calhoun St.</b>		DATE SIGNED <b>3/21/70</b>	

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 3051
M-650		70 3051		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Moran, Richard Thomas</i>		2. DATE AND HOUR OF DEATH <i>3/18/70 8:05 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		2634	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>5035 Wright Ave</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-08-04</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ASSISTANT BREWER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AMERICAN BREWERY</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO, Md.</i>	
13. FATHER'S NAME <i>Edward Moran</i>		14. MOTHER'S MAIDEN NAME <i>Pearl (Moran) BALANCE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-0225A</i>		17. INFORMANT <i>MRS. LAZETTA A. MORAN</i>	
(If yes, give war or dates of service)		ADDRESS <i>SAME</i>			
18. <i>57411</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>RESPIRATORY FAILURE, GRAM NEG SEPSIS</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>PNEUMONIC PNEUMONIA &amp; CAUTARIAN</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>COMMON BILE DUCT STONES &amp; CHOLANGITIS</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12</i> <i>1969</i> to <i>3/18</i> <i>1970</i> , that (I) (we) last saw the deceased alive on <i>3/18</i> <i>1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>David Lerberg, MD</i>		23B. DATE SIGNED <i>3/18/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>David Lerberg, M.D.</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-21-1970</i>		24C. NAME of CEMETERY or CREMATORY <i>NEW CATHEDRAL</i>	
24D. LOCATION <i>BALTO, Md.</i>		(City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <i>MAR 23 1970</i>		25B. NAME OF REGISTRAR <i>JOSE J. [illegible]</i>		25C. FUNERAL DIRECTOR <i>J. Walter Conklin</i>	
				ADDRESS <i>5444 BELAIR Rd.</i>	

10-10-1918

Common. The first, second & third  
specimens were taken from the same place.

10-10-1918

10-10-1918

10-10-1918

10-10-1918

10-10-1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

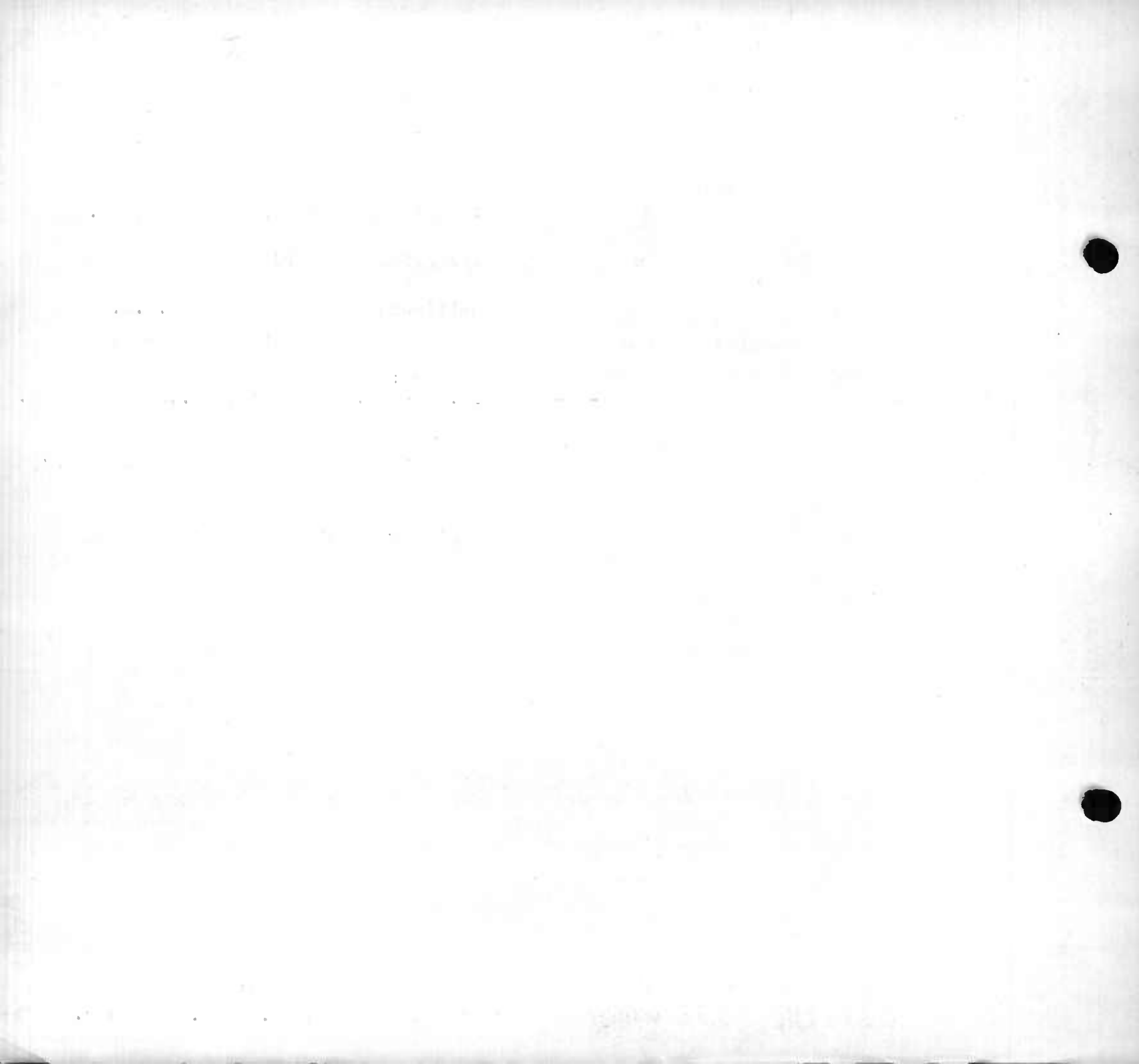
BALTIMORE CITY HEALTH DEPARTMENT				70 3052		REG. NO. 70 3052	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MR. CHESTER WOODK</u>		2. DATE AND HOUR OF DEATH <u>MARCH 22, 1970 10:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME AND HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>104</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME AND HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2106 FLEET ST.</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/17</u>		9. AGE (In years last birthday) <u>52</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Krager Millwork</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>JOHN WOODK</u>				14. MOTHER'S MAIDEN NAME <u>ANNA KLIMEK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> World War II		16. SOCIAL SECURITY NO. <u>212-03-7756</u>		17. INFORMANT <u>Mary Piechocki - 2106 Fleet St. #21231</u>			
18. <u>4/10/9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic Cardiovascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II Pulmonary Edema</u> <u>HOURS</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>MARCH 22</u> 19 <u>70</u> to <u>MARCH 22</u> 19 <u>70</u> that <del>we</del> (we) last saw the deceased alive on <u>MARCH 22</u> 19 <u>70</u> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Cesar A. Lopez MD</u>				23B. DATE SIGNED <u>MARCH 22, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>CEZAR A. LOPEZ MD</u>				23D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/25/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fahey, M.D.</u>		25C. FUNERAL DIRECTOR <u>George A. Weber - 705 S. Ann St. #21231</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3053</span>
BIRTH NO. <span style="font-size: 1.5em;">70 3053</span>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>MARY HELEN HOPKINS LEACH</b>		2. DATE AND HOUR OF DEATH <b>March 21, 1970</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">004 East 32nd Street</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1202</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4 East 32nd Street, Baltimore, Md. 21218</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>1/12/1900</b>
13. FATHER'S NAME <b>Charles Hopkins</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		9. AGE (In years last birthday) <b>70</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Sally Gardner Dove</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
16. SOCIAL SECURITY NO. <b>216-46-0728</b>		17. INFORMANT : <b>Daughter</b> <b>Mrs. John D. Alexander, Jr., 1419 John St.</b>		
18. <span style="font-size: 1.5em;">153.81</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>Multiple metastases</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>Carcinoma of colon</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <span style="font-size: 1.5em;">1965</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Jan</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">Mar 21</span> 19 <span style="font-size: 1.5em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.5em;">RK Gundry MD</span> 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">RK Gundry</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">3-23-70</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">J. E. Taylor, R.D.</span>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOYEN</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		ADDRESS <b>C.O. 108 W. North Ave. 21201</b>		

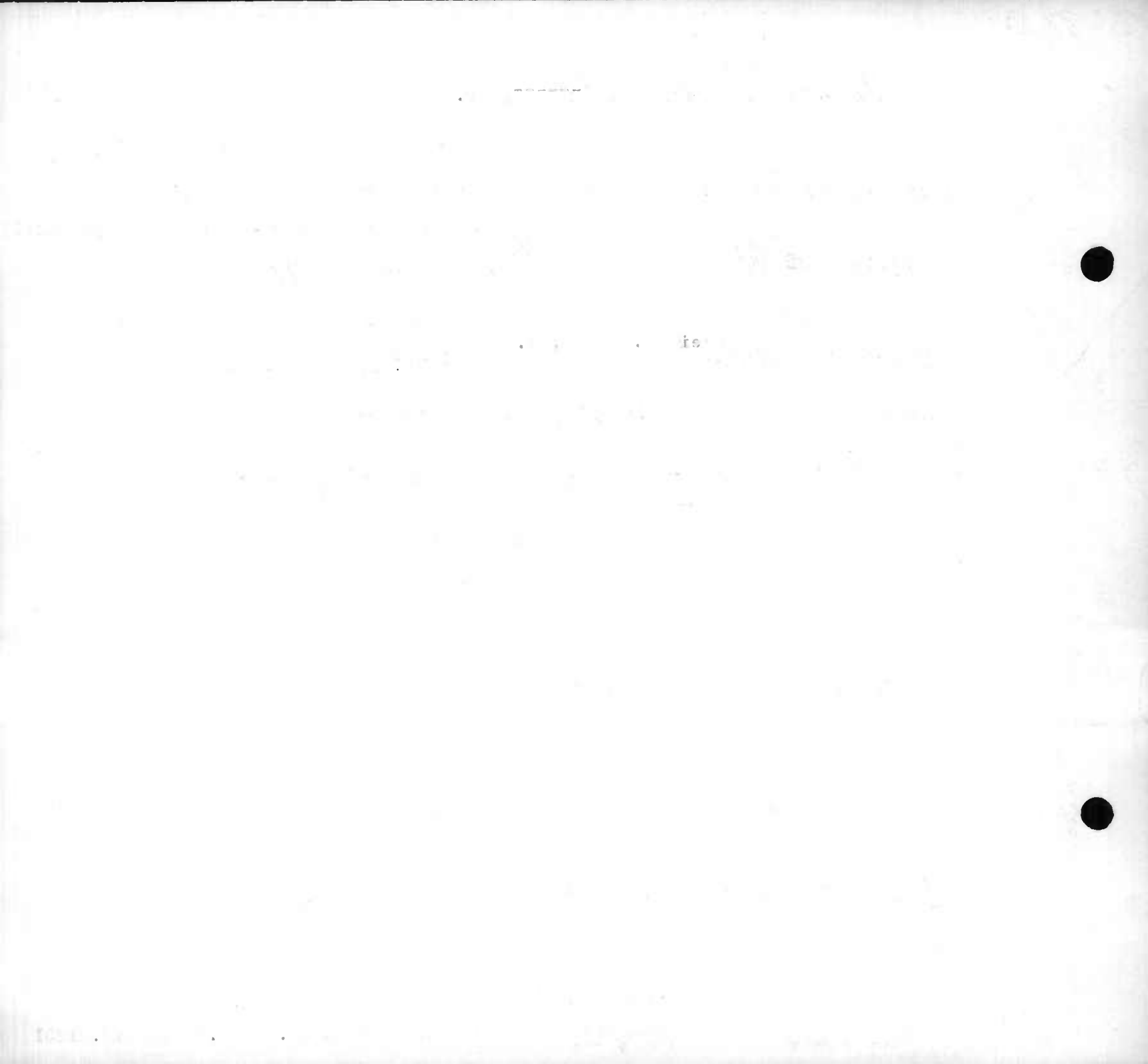




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

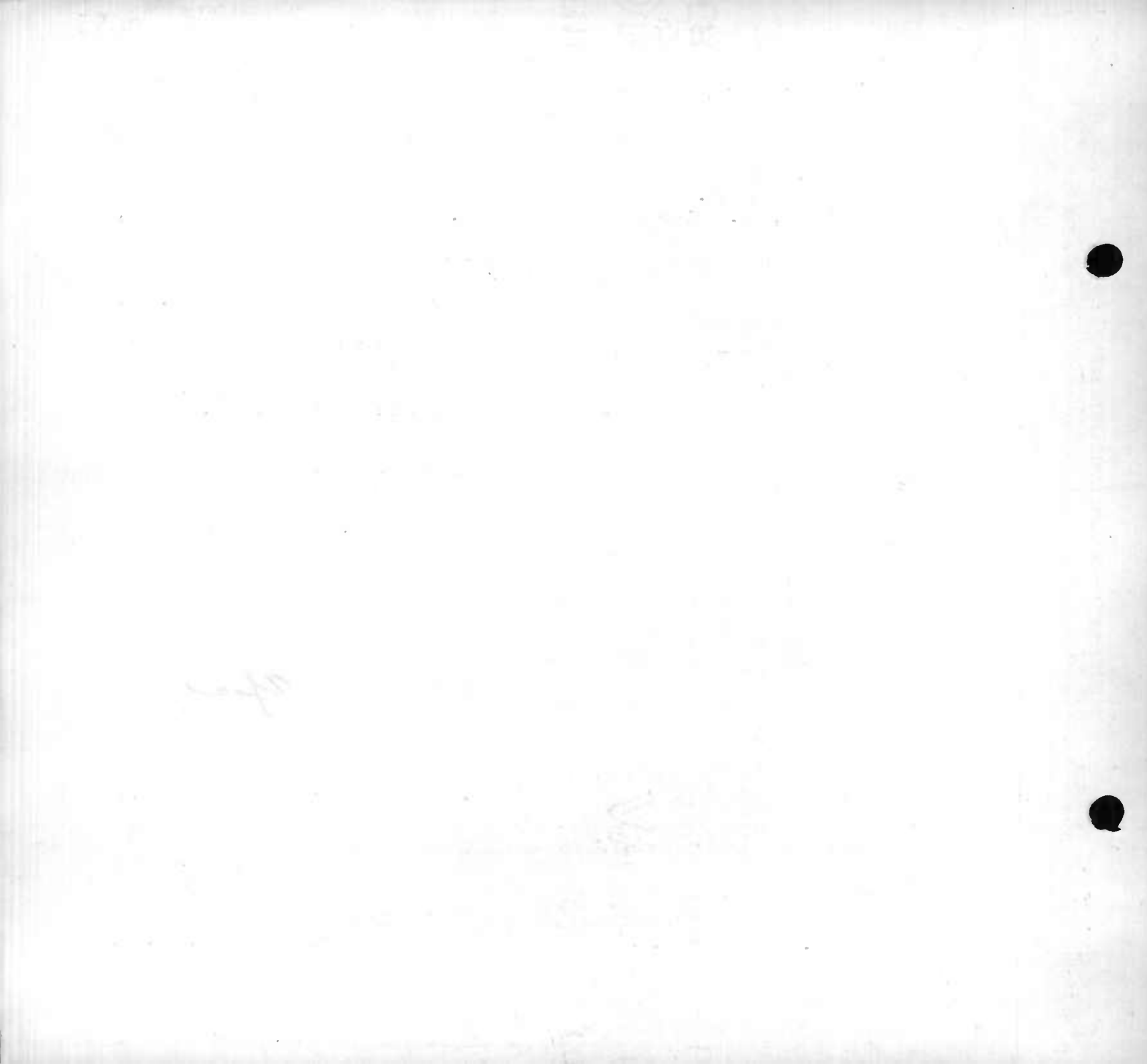
BALTIMORE CITY HEALTH DEPARTMENT		70 3054		REG. NO. 70 3054	
BIRTH NO. 70 3054				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Julein Bowdre, Julian Leon (Jr.), Jr.</b>		2. DATE AND HOUR OF DEATH <b>3/21/70 5:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>North Charles General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21202 (21217)</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>North Charles General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>1401</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12/16/98</b>	
13. FATHER'S NAME <b>Bowdre, Julian</b>		14. MOTHER'S MAIDEN NAME <b>Moale, Dora (Medora Moale)</b>		9. AGE (In years last birthday) <b>71</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO ?</b>		16. SOCIAL SECURITY NO. <b>213-05-6361 A</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
17. INFORMANT <b>NC6H chart</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		ADDRESS	
18. <b>57181</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEPATIC FAILURE</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>BILIARY CIRRHOSIS and</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>OBSTRUCTIVE JAUNDICE</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/19/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>obstructive jaundice</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> 19 <b>70</b> to <b>3-21</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francis F. Fryer, M.D.</b>		23B. DATE SIGNED <b>3/21/70</b>		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Green Mount Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. NORTH AVE. 21201</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

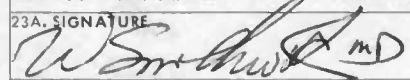
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 3055		CERTIFICATE OF DEATH		REG. NO. 70 3055	
1. NAME OF DECEASED (Type or Print) <u>William Hall</u>				2. DATE AND HOUR OF DEATH <u>3-22-70</u> <u>11<sup>15</sup></u> <u>P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-2-07</u>		9. AGE (In years last birthday) <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Louis Hall</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Evans</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-18-2533</u>		17. INFORMANT ADDRESS <u>4940 Eastern Ave,</u> <u>BCH Records: Baltimore, Md. 21224</u>	
18. <u>200.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>RETICULUM CELL SARCOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Intracranial Metastases</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Broncho pneumonia</u>						<u>1 wk</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 15</u> 19 <u>70</u> to <u>March 22</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>March 20</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dale N. Schumacher</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-22-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dale N. Schumacher M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave, Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		24D. LOCATION (City, town, or county) (State) <u>Wormy</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>William Reese #111111</u>		ADDRESS <u>William Reese #111111</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>T-460</b>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3056</b>	
1. NAME OF DECEASED (Type or Print) <b>TAYLOR, James Edward</b>				2. DATE AND HOUR OF DEATH <b>22 MARCH 1970 11:55 AM M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1402 FILLMORE</b>							
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-33</b>	9. AGE (In years last birthday) <b>36</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>FARMSVILLE, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>WILLIAM LAWSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY ANNE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>11-29-51 TO 2-5-54 219-28-4247</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>	
18. CAUSE OF DEATH I <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTESTINAL OBSTRUCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA OF COLON</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: 20 DAYS</b> <b>2 YEARS</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>14 FEBRUARY 1970</b> to <b>22 MARCH 1970</b> , that <del>he</del> (we) last saw the deceased alive on <b>22 MARCH 1970</b> and that <del>he</del> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (submit) view the body after death.							
23A. SIGNATURE  DEGREE				23B. DATE SIGNED <b>3-22-70</b>		23C. PHYSICIAN'S NAME (Type) <b>WALTER SMITHWICK, MD</b>	
23D. ADDRESS <b>3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218</b>							
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>1-448</u>	
C-462		70 3057		70 3057	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Clark, Beatrice</u>		
2. DATE AND HOUR OF DEATH <u>3-17-70</u> <u>6:05 P.M.</u>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>1007 W. Lafayette Ave</u> B. COUNTY <u>1601</u>			5. CITY OR TOWN <u>Baltimore, Md.</u>		
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7. STREET AND NUMBER		
8. SEX <u>Female</u>		9. RACE <u>n</u>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. DATE OF BIRTH <u>3-29-07</u>		12. AGE (In years last birthday) <u>62</u>		13. If Under 1 Yr. Months: Days: Hours: Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		16. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
17. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		18. FATHER'S NAME <u>William Green</u>		19. MOTHER'S MAIDEN NAME <u>Beatha McAlaine</u>	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		21. SOCIAL SECURITY NO. <u>108-26-3073</u>		22. INFORMANT <u>Rebecca Campbell</u>	
23. ADDRESS <u>1007 Lafayette Ave</u>		24. CAUSE OF DEATH		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia, CHF</u>		27. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		28. ANTECEDENT CAUSES	
29. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		30. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		31. ANTECEDENT CAUSES	
32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Obesity</u>		33. DATE OF OPERATION <u>0</u>		34. CONDITION FOR WHICH OPERATION WAS PERFORMED	
35. AUTOPSY? (Yes or No)		36. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		37. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
38. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		39. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		40. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
41. HOW DID INJURY OCCUR?		42. I certify that (I) (this hospital) attended the deceased from <u>11-7-1969</u> to <u>3-17-1970</u>		43. that (I) (we) last saw the deceased alive on <u>3-17-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
44. SIGNATURE <u>[Signature]</u>		45. DATE SIGNED <u>3/18/70</u>		46. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
47. PHYSICIAN'S NAME (Type) <u>T. HORN</u>		48. ADDRESS <u>1213 Light St.</u>		49. DATE OF OPERATION <u>0</u>	
50. NAME OF CEMETERY OR CREMATORY <u>CARVER Mem PK.</u>		51. LOCATION (City, town, or county) <u>Laurel Md.</u>		52. DATE OF OPERATION <u>0</u>	
53. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		54. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		55. FUNERAL DIRECTOR <u>MORTON + DYETT F.H.</u>	
56. ADDRESS <u>1701 LAURENS</u>		57. DATE OF OPERATION <u>0</u>		58. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3058	
P-362		70 3058		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PETERS GLADYS, Sophournia		2. DATE AND HOUR OF DEATH 3/20/70 7.05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 2101 LONGWOOD STREET			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY BEAUTY SALON		8. DATE OF BIRTH 6/22/18	
13. FATHER'S NAME Adolphus Harper		14. MOTHER'S MAIDEN NAME Tanner Coleman		9. AGE (in years last birthday) 51	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT		ADDRESS			
18. 736.9 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CEREBRAL VASCULAR ACCIDENT. DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 20 1970 to March 20 1970 that (H) (we) lost saw the deceased alive on March 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/20/70	
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS M.D. DEGREE		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/70		24C. NAME OF CEMETERY OR CREMATORY Balt. Nat'l Cem.	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mortens Dyer FH	
ADDRESS		1701 Laurens St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550		70 3059		BALTIMORE CITY HEALTH DEPARTMENT		70 3059	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>THOMAS J. LEMMON (Lemon)</u>				2. DATE AND HOUR OF DEATH <u>3/21/69</u> <u>70</u> <u>4:20</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2102</u>			
5. SEX <u>M</u>				6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/25/23</u>				9. AGE (In years last birthday) <u>46</u>		10. IF UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>BENJAMIN LEMMON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>1944-45</u>				16. SOCIAL SECURITY NO. <u>R13-20-2687</u>		17. INFORMANT <u>ANNE LEMMON (WIFE)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE PULMONARY EDEMA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CA OF LIVER WITH METASTASIS</u>				(B) <u>4 mos</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
21A. DATE OF OPERATION: <u>8</u>				21B. CONDITION FOR WHICH OPERATION WAS PERFORMED: <u>8</u>		21C. AUTOPSY? (Yes or No) <u>NO</u>	
22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>8</u>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>8</u>	
23A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>3/21/70</u>				23B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		23C. HOW DID INJURY OCCUR? <u>70</u>	
24. I certify that (I) (this hospital) attended the deceased from <u>3/21/70</u> to <u>3/21/70</u> and that (I) (we) lost saw the deceased alive on <u>3/21/70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
25A. SIGNATURE <u>Bruce Fleeger M.D.</u>				25B. DATE SIGNED <u>3/21/69</u>		25C. PHYSICIAN'S NAME (Type) <u>Bruce Fleeger</u>	
26A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				26B. DATE <u>3/25/70</u>		26C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem.</u>	
27A. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>				27B. ADDRESS <u>1701 Laurens St</u>			
28A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 23 1970</u>				28B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		28C. FUNERAL DIRECTOR <u>Morton's Dyett F.H.</u>	

Confirmed on 'phone with Miss Perno of  
University Hospital 4-7-70 M.H.  
Also V.S. 153 4-10-70 M.H.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3060

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Doris (Nolan) BRAGGS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET, HOUSE NO., ADDRESS OR LOCATION Maryland General Hospital 7-31-70		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 20 70 3:45 a.m.	
6. SEX female		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4-17-1945		10. AGE (In years lost birthday) 24	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leroy James		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
15. MOTHER'S MAIDEN NAME Alline James		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT M's Shirley James	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL MYOCARDITIS <del>Arteriosclerotic cardiovascular disease</del> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 3/20/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-70	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	



# FUNERAL DIRECTOR: IMPORTANT

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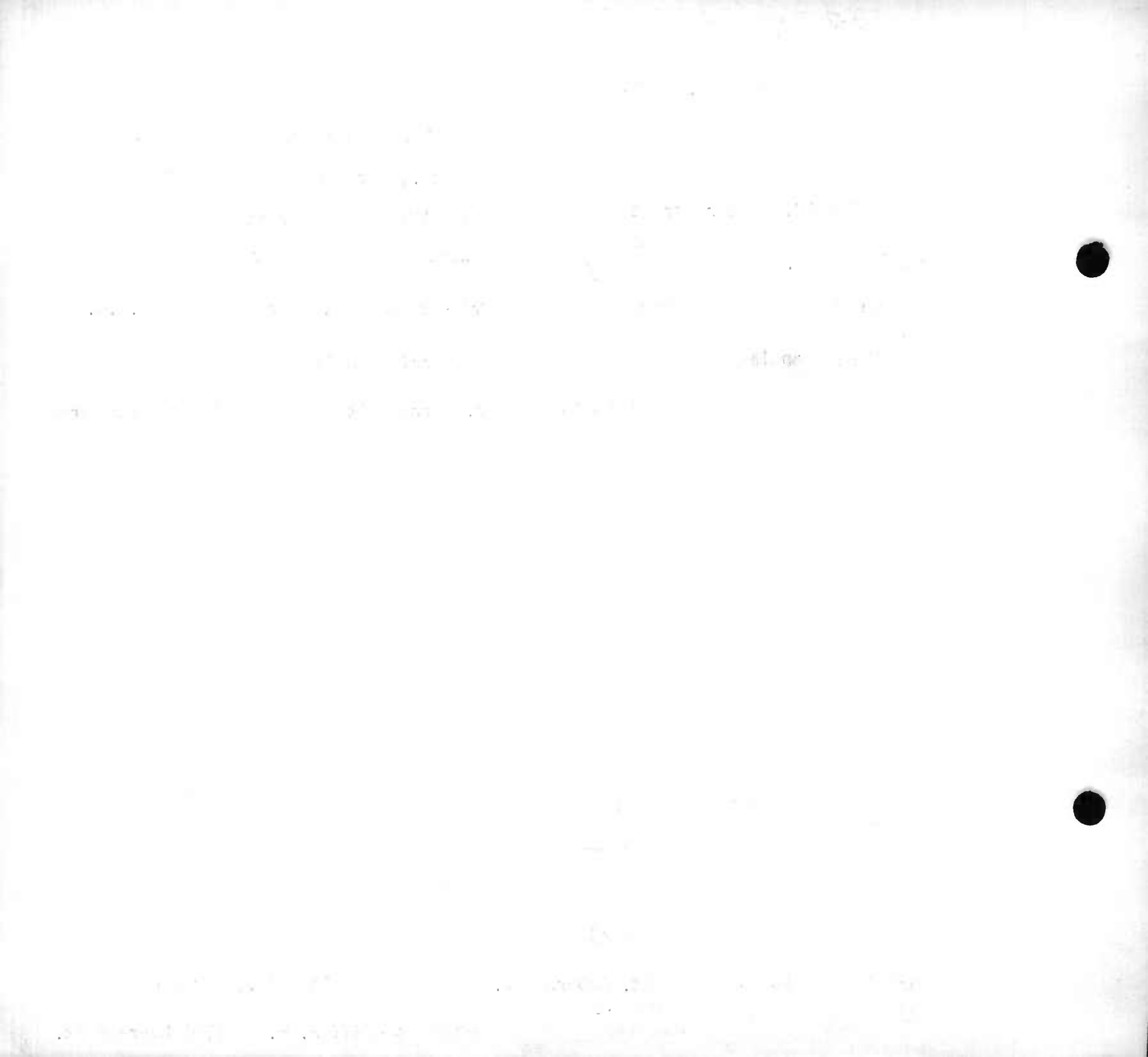
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3061	
7-520 70 3061				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lavonia Thomas		March 18, 1970 3:00 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE CITY 1703		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1209 Myrtle Ave		
5. SEX FEMALE	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-18	9. AGE (in years last birthday) 52	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Fredrick, MD.	
13. FATHER'S NAME JOHN THOMAS			14. MOTHER'S MAIDEN NAME MARGIE M. Thomas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Dorothy H. Thomas 1209 Myrtle ave.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (R) cerebrovascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days 15 years 7 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Asotemia Anemia		Chronic urinary tract infection H/O (C) CVA	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from March 2, 1970 to March 18, 1970 that (1) (we) lost saw the deceased alive on March 18, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas E. Davis MD			23B. DATE SIGNED March 18, 1970		23C. PHYSICIAN'S NAME (Type) Thomas E. Davis MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-24-70		24C. NAME OF CEMETERY or CREMATORY Friendship Meth. Ch. CEM.
24D. LOCATION DAMASCUS, MARYLAND			24E. NAME OF REGISTRAR Morton E. Durr		24F. FUNERAL DIRECTOR Morton E. Durr
24G. DATE AND HOUR OF HEALTH DEPT. REGISTRATION MAR 23 1970			24H. NAME OF REGISTRAR Morton E. Durr		24I. FUNERAL DIRECTOR Morton E. Durr
24J. ADDRESS 1701 LAURENS ST.			24K. ADDRESS 1701 LAURENS ST.		24L. ADDRESS 1701 LAURENS ST.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3062</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">S-530 70 3062</span>					
1. NAME OF DECEASED (Type or Print) <span style="float: right;">EMILY D. SMITH</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">MARCH 20, 1970 3<sup>00</sup> P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="float: right;">2749 Winchester Street</span>			A. STATE B. COUNTY <span style="float: right;">1607</span>		
			C. CITY OR TOWN <span style="float: right;">Balto., Maryland</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="float: right;">2749 Winchester Street</span>		
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">N.</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">4-12-1906</span>	9. AGE (In years last birthday) <span style="float: right;">63</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Home</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Princess Ann Co., Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>		13. FATHER'S NAME <span style="float: right;">Thomas Dennis</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Carrie Dennis</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">NO</span>		16. SOCIAL SECURITY NO. <span style="float: right;">212-32-1733</span>		17. INFORMANT <span style="float: right;">Mr. Harry Smith</span>	
				ADDRESS <span style="float: right;">2749 Winchester Street</span>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">4-12-21</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">2 YRS.</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</span>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <span style="float: right;">June 19 69</span> to <span style="float: right;">March 20 19 70</span> that (1) (we) last saw the deceased alive on <span style="float: right;">Feb 20 19 70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">B. S. Karpas Jr. M.D.</span>				23B. DATE SIGNED <span style="float: right;">3/20/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">B. S. KARPAS JR. M.D.</span>				23D. ADDRESS <span style="float: right;">University of Maryland Hospital Baltimore, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="float: right;">3-23-70</span>		24C. NAME of CEMETERY or CREMATORY <span style="float: right;">Mt. Auburn Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore., Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">MAR 23 1970</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="float: right;">MORTON &amp; DYETT F. H.</span>	
				ADDRESS <span style="float: right;">1701 Laurens St.</span>	



D-120 70

3063

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3063

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Willie Davis</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 20 70 7:25 a. m.</b>	
6. SEX <b>male</b>		7. RACE <b>colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1502</b>	
9. DATE OF BIRTH <b>6-13-1918</b>		10. AGE (In years last birthday) <b>51</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Zebulon, North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disable</b>		13. FATHER'S NAME <b>Will H. Davis</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		15. MOTHER'S MAIDEN NAME <b>N/A</b>	
17. SOCIAL SECURITY NO. <b>218-14-0220</b>		18. INFORMANT ADDRESS <b>Mrs. Fannie F. Davis 1322 N. Mount Street</b>	
19. <b>41221</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21. AUTOPSY? (Yes or No) <b>yes</b>	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED <b>3/20/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Stoke's Chapel Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Zebulon, North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DETT FH.</b>		ADDRESS <b>1701 Laurens St.</b>	

ACADEMY OF ARTS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-600 70 3064</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 70 3064</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DOROTHY P. MOORE</b>		2. DATE AND HOUR OF DEATH <b>MARCH 21, 1970 11:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>01-01-11</b>		9. AGE (In years last birthday) <b>59</b>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>HOWARD S. PHILLIPS</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE SCHOFF</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-112-1310</b>		17. INFORMANT <b>Mr Turner Moore</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DIABETES MELLITUS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>MARCH 18, 1970</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERIPHERAL VASCULAR DISEASE</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <b>NO</b> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (t) (this hospital) attended the deceased from <b>MARCH 16, 1970</b> to <b>MARCH 21, 1970</b> that (t) (we) last saw the deceased alive on <b>MARCH 21, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>[Signature]</b> 23B. DATE SIGNED <b>MARCH 21, 1970</b> 23C. PHYSICIAN'S NAME (Type) <b>MIGUEL SANCHEZ-PALACIOS</b> 23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b> 24B. DATE <b>3/25/70</b> 24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b> 24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b> 25B. NAME OF REGISTRAR <b>[Signature]</b> 25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b> ADDRESS <b>Baltimore, Maryland</b>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-620 70 3065				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3065	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>FARISH, ANNIE Pearl</b>				2. DATE AND HOUR OF DEATH <b>3/22/70 4 40/ A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  E. STREET AND NUMBER <b>1507 Odell Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/20</b>		9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Richard Sprouse</b>				14. MOTHER'S MAIDEN NAME <b>Lillie May Donovan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>BCH Records- 4940 Eastern Avenue Baltimore, Md. 21224</b>			
18. <b>4/10/70</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>it</del> (this hospital) attended the deceased from <b>3/22</b> <b>1970</b> to <b>3/22</b> <b>1970</b> , that <del>it</del> (we) last saw the deceased alive on <b>3/22</b> <b>1970</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <b>Dennis W. Bleakley M.D.</b>				23B. DATE SIGNED <b>3/22/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dennis W. Bleakley M.D.</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70.</b>		24C. NAME of CEMETERY or CREMATORY <b>Molden Baptist Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Red Hill, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR <b>Leonard A. Buck, Inc. Balto. Md. 21214</b>		25D. ADDRESS <b>Leonard A. Buck, Inc.</b>	

James M. Smith

James M. Smith

James M. Smith



B-560

70 3066

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3066

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CHRISTINE BENNER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 9:40 P.M.</b>	
6. SEX <b>Female</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Baltimore</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Oct. 15, 1921.</b>		10. AGE (In years lost birthday) <b>48</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Muller</b>		E. STREET AND NUMBER <b>4919 Morello Road</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Elizabeth Mack</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-12-5932</b>	
18. INFORMANT <b>Mr. Paul Benner</b>		ADDRESS <b>(Same)</b>	
19. <b>E-98010</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Overdose of Barbiture</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Overdose of Barbiture</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4919 Morello Road</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>3-15-70 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject ingested overdose of barbiturate</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/21/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70.</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	

Oct. 15, 1991

Virginia

Honorable

To

USA

Peter Miller

Elizabeth Mack

(Name)

218-12-2932 Mr. Paul Bonner

WALTER J. BOK

WALTER J. BOK

WALTER J. BOK

WALTER J. BOK

Walter

3/26/70

Baltimore National Cemetery

Baltimore, Md.

Leonard J. Mack, Inc. Baltimore, Md. 21211

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 3067</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">70 3067</span>	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Lemanuel Arthur Doame, Sr.</b>			Mar. 23, 1970 4:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 2100 Wyman Parkway</b>			A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Kingsville</b>		
			D. STREET ADDRESS (If rural, give location) <b>Route 1 Belair Rd.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5/12/90</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	11. BIRTHPLACE (State or foreign country) <b>Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frederick Doame</b>			14. MOTHER'S MAIDEN NAME <b>Anna Horton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USN 10-2-42-45</b>		16. SOCIAL SECURITY NO. <b>212-26-7109</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) <b>Respiratory arrest</b> <b>Terminal</b>		
ANTECEDENT CAUSES			(B) <b>Chronic obstructive pulmonary disease</b> <b>Years</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			<b>Chronic congestive heart failure</b> <b>Years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Status post myocardial infarction</b> <b>Years</b>		
			<b>Arteriosclerotic cardiovascular disease</b> <b>Years</b>		
19A. DATE OF OPERATION <b>3-19-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Mar. 18 1970</b> to <b>Mar. 23 1970</b> , that (I) (we) last saw the deceased alive on <b>Mar. 23 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wilmer J. Keener</b>				23B. DATE SIGNED <b>3/23/70 RGB</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wilmer J. Keener, SA Surg (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70.</b>		24C. NAME of CEMETERY or CREMATORY <b>Arlington National Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3068</u>	
M-625 70 3068				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Morgan, Mae Lucinda</u>		2. DATE AND HOUR OF DEATH <u>March 19<sup>th</sup> 1970 4<sup>25</sup> P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Del.</u> B. COUNTY <u>Kent</u>		V-07	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Dover</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1616 Nathaniel Mitchel Rd.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-03</u>	9. AGE (In years last birthday) <u>66</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George W. Spangler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Everett</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Paul K. Morgan, 1616 Nathaniel Mitchel Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Probable Acute MI</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Broncho pneumonia</u>		DUE TO, OR AS A CONSEQUENCE OF: (B) <u>2 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Acute Myelogenous Leukemia</u>		DUE TO, OR AS A CONSEQUENCE OF: (C) <u>4 mo.</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>March 11 19 70</u> to <u>March 19 19 70</u> that (I) (we) last saw the deceased alive on <u>March 19 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard J. O'Brien M.D.</u>		23B. DATE SIGNED <u>3/19/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard J. O'Brien M.D.</u>	
23D. ADDRESS <u>University Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Sunset Memorial Park,</u>		24D. LOCATION (City, town, or county) (State) <u>Cumberland, Allegany Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. Wayne George</u>		25D. ADDRESS <u>202 Greene St. Cumberland, Md.</u>	

University of Michigan

X

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Homework

Record in 2 hours

W.

X

Let's make a list

4-2-52

W. 2

Exercises 2 hours

Exercises 2 hours

Exercises 2 hours

Exercises 2 hours

W.

X

Exercises 2 hours

Exercises 2 hours

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3069
C-434 70 3069				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Robert P Caldwell</i>		2. DATE AND HOUR OF DEATH <i>March 18, 1970 1 845 P</i> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Carroll</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>		C. CITY OR TOWN <i>Manchester</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B. &amp; O</i>		8. DATE OF BIRTH <i>May 29, 1918</i>
13. FATHER'S NAME <i>Guy Caldwell</i>		14. MOTHER'S MAIDEN NAME <i>Adria Ellison</i>		9. AGE (In years last birthday) <i>51</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-01-9335</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>
		17. INFORMANT <i>Daughter - Susan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pul. Sparuthrichosis</i>		<i>5 yrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <i>May</i> 19 <i>67</i> to <i>Mar 18</i> 19 <i>70</i> that (1) (we) last saw the deceased alive on <i>Mar 18</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Richard B. Hornick MD</i>				23B. DATE SIGNED <i>Mar. 18, 1970</i>
23C. PHYSICIAN'S NAME (Type) <i>Richard B. Hornick</i>		23D. ADDRESS <i>Univ. of Maryland Hosp. Balt. Md</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>March 21, 70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1970</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR <i>Tipton-Elise Funeral Home</i>
				ADDRESS <i>Hampstead, Md.</i>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
BIRTH NO. <b>H-530</b>		<b>70 3070</b>		<b>70 3070</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Lula Martin Hunt</b>			2. DATE AND HOUR OF DEATH <b>March 17 1970 305</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 W. 33rd Street</b>			A. STATE <b>BALTO</b>		
(If not in hospital or institution, give street address or location)			B. COUNTY <b>1306</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
<b>610 33rd Street</b>			<b>610 W 33rd Street</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)	8. DATE OF BIRTH <b>Dec 11 1878</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO CO</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Mordcaia Price</b>		14. MOTHER'S MAIDEN NAME <b>Brache II Armacost</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-8456</b>		17. INFORMANT ADDRESS <b>Miss Evelyn Martin BALTO Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>485X1</b>			CAUSE OF DEATH <b>Broncho-Pneumonia</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 24 1968</b> to <b>March 17 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wm G Hilgush</b>				23B. DATE SIGNED <b>3-18-70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M.D.				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Forrest Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO CO Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jolley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Tipton Eline Funeral Home Hampstead</b>			

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10/22/21  
T

Marcelin Price

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612 2nd St  
Trenton, N.J.

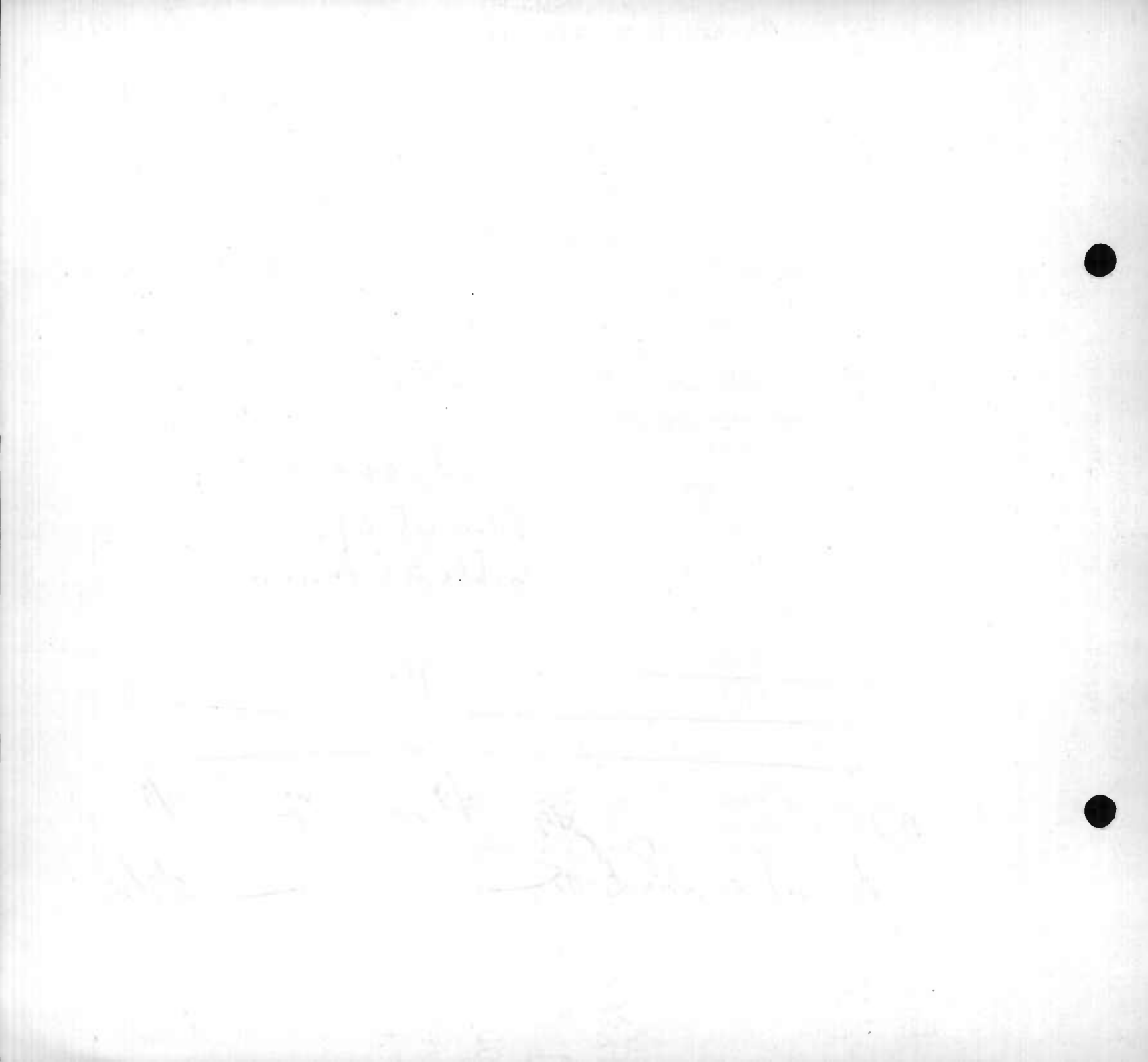
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Marcelin Price  
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Marcelin Price

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3071	
BIRTH NO. S-536 70 3071		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>AMELIA SMOTHERS (Theresa)</i>		2. DATE AND HOUR OF DEATH <i>3/9/70 5:25 P M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>1513</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4326 Pimlico Rd.</i>					
5. SEX <i>F</i>	6. RACE <i>N N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-23-65</i>	9. AGE (In years last birthday) <i>4 1/2</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Charles Smathers</i>			
14. MOTHER'S MAIDEN NAME <i>Lais Edwards</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles Smathers</i>		ADDRESS <i>Same</i>	
18. <i>2824</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiovascular collapse</i>			
ANTECEDENT CAUSES		(B) <i>Presumed sepsis</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Sickle cell disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/9</i> <i>19 70</i> to <i>3/9</i> <i>19 70</i> , that (I) (we) last saw the deceased alive on <i>3/9</i> <i>19 70</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth D. Roberts M.D.</i>		23B. DATE SIGNED <i>5/9/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>KENNETH D. ROBERTS M.D.</i>		23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-14-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Aslington Phillips 1727 N. Meade</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3072	
2-460 70 3072				70 3072	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ZELLER, VALENTINE</b>				2. DATE AND HOUR OF DEATH <b>3-20-70 11:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Balt. Gen. 73</b>				C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1417 Andre ST 21230</b>					
5. SEX <b>M</b>	6. RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-05</b>	9. AGE (In years last birthday) <b>64</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work, if not working, give last one, even if retired) <b>Shipyard Dept</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>J. Schoenman Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William Zeller</b>		
14. MOTHER'S MAIDEN NAME <b>Helen Stumpher</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213-01-7298</b>			17. INFORMANT <b>Mrs. Minnie Zeller 1417 Andre ST.</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Profound Cardiovascular Collapse</b>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>					
(C) YEARS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> 19 <b>70</b> to <b>3-20</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-20</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald M. Wood, M.D.</b>				23B. DATE SIGNED <b>3-20-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD M. WOOD, M.D.</b>				23D. ADDRESS <b>SOUTH BALTO GEN.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Glenn Haven Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Danvers, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3073</u>
1. NAME OF DECEASED (Type or Print) <u>Heyrman, ANNIE AILEEN</u>		2. DATE AND HOUR OF DEATH <u>3-20-70 @ 2:15 pm</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1201</u>		
FULL NAME OF HOSPITAL OR INSTITUTION  <u>44 Union Memorial Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>		8. DATE OF BIRTH <u>4-23-1914</u> 9. AGE (In years last birthday) <u>55</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ferdinand C. Latrobe</u>		14. MOTHER'S MAIDEN NAME <u>Aileen Ford</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John H. Heyrman</u>
18. I <u>15271</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Massive gastrointestinal hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Adenocarcinoma jejunum</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>Nov 11 1969</u> to <u>March 20 1970</u> that (1) (we) last saw the deceased alive on <u>March 20 1970</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>RK Gundry MD</u>		23B. DATE SIGNED <u>3-20-70</u>		23C. PHYSICIAN'S NAME (Type) <u>RK GUNDRY</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-24-70</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>
MAR 23 1970		25D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		25E. ADDRESS <u>4905 York Road Balto., Md.</u>

Abstracts of papers presented at the 1980 Annual Meeting of the American Psychological Association, Washington, D.C., September 1-5, 1980.

[illegible]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

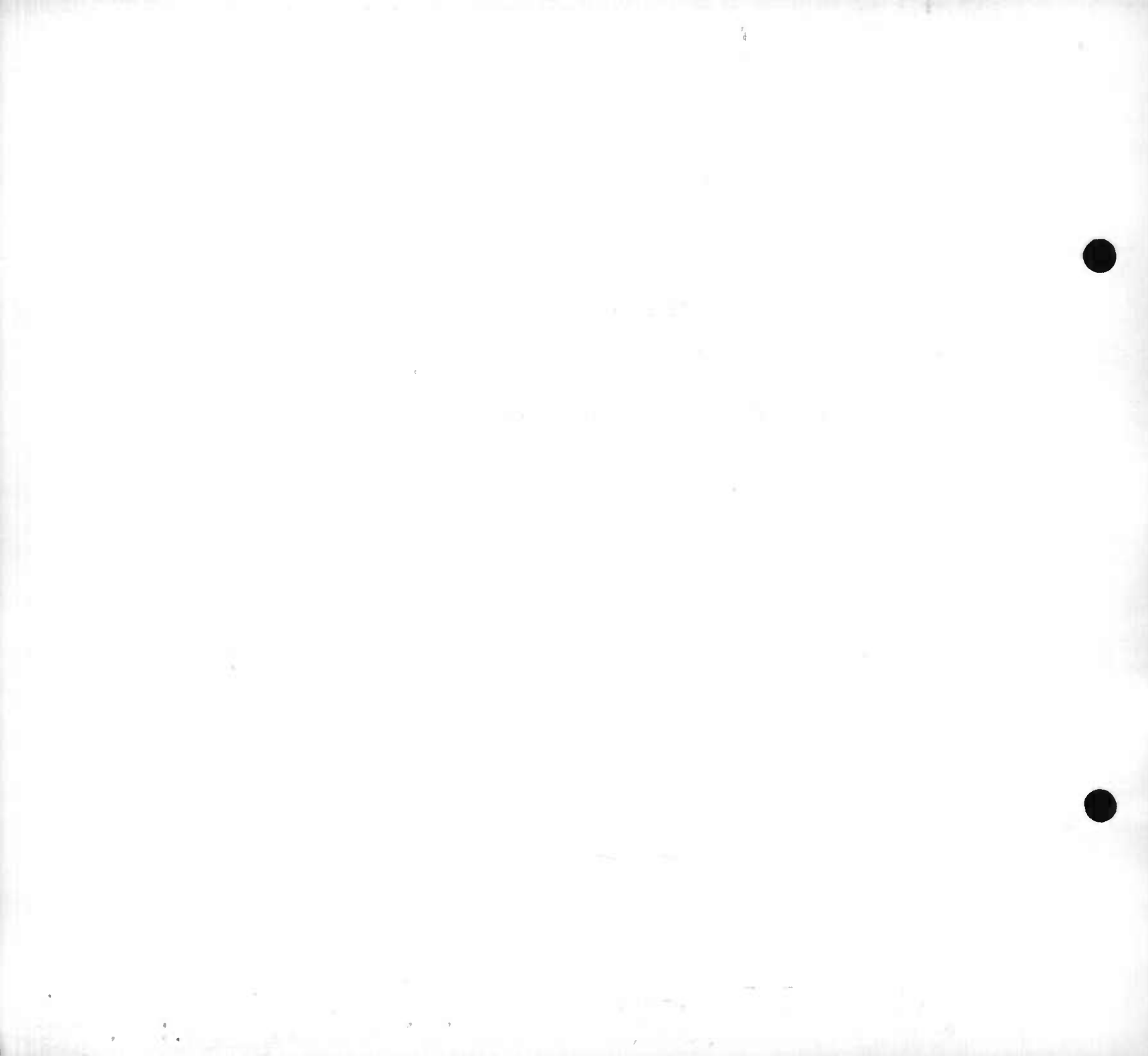
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 3074</u>	
BIRTH NO. <u>7-645</u> <u>70 3074</u>				1. NAME OF DECEASED (Type or Print) <u>ANNA FURLONG</u>		2. DATE AND HOUR OF DEATH <u>3-20-70</u> <u>6 PM</u> - M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House In The Pines</u> <u>5837 Belair Road</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3501 St. Paul Street</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1878</u>		9. AGE (In years last birthday) <u>91</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Patrick Furlong</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Murphy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-50-7152</u>		17. INFORMANT <u>Miss Katherine Furlong</u> ADDRESS <u>3865 Lyndale Ave.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1 - acute coronary thrombosis</u> <u>2 - acute congestive failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>3 - art. scl. C.V.D. - 2 months</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>- 3 hr duration</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>10-28-1969</u> to <u>March 20, 1970</u> and that (1) (we) last saw the deceased alive on <u>March 20, 1970</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Bernard J. Cohen, M.D.</u>				23B. DATE SIGNED <u>3/20/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>BERNARD J. COHEN, M.D.</u>				23D. ADDRESS <u>The Marylanders apt 3501 St. Paul St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-24-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>			



# FUNERAL DIRECTOR: IMPORTANT

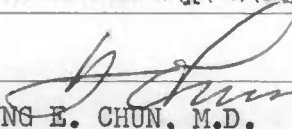
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-512 70 3075				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3075	
1. NAME OF DECEASED (Type or Print) <b>DR. DANIEL S. HINEBAUGH</b>				2. DATE AND HOUR OF DEATH <b>MARCH 22, 1970 1:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1202</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3204 GREENMOUNT AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 7, 1898</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TEETH</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>(AMERICAN) U.S.A.</b>	
13. FATHER'S NAME <b>H.F.E. HINEBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>CORA MAUTE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>213-12-2977A</b>		17. INFORMANT <b>SALLY SCHOLKOPF</b>		ADDRESS <b>616 HOLMSEAD ST., BALTO., MD.</b>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the Lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>w/ Metastasis to the Brain</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic Heart Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 10 1970</b> to <b>MARCH 22 1970</b> that (I) (we) last saw the deceased alive on <b>MARCH 22 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Yu. Sui Lit</b>				23B. DATE SIGNED <b>3/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>YU. SUI LIT</b>	
23D. ADDRESS <b>M.D. UNION MEMORIAL HOSP., BALTO., MD.</b>				23E. DEGREE <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Timonium, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaeger, M.D.</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>			
				ADDRESS <b>4905 York Road Balto., Md. 21212</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3076</span>	
C-636 70 3076				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARTER, Major NMI		18 MARCH 1970 1:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> <span style="font-size: 1.5em;">1004</span>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>404 EAST CHASE STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-02</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>REYNOLDS, GEORGIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>MAJOR CARTER</b>		14. MOTHER'S MAIDEN NAME <b>ELSIE MATHIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 9-14-42 TO 5-25-43</b>		16. SOCIAL SECURITY NO. <b>212-16-96-30</b>		17. INFORMANT <b>VA HOSPITAL RECORDS</b> ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD</b>	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>			days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Chronic glomerulonephritis</b> years		
			(C) _____		
II			Arteriosclerotic heart disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>16 JANUARY 19 70</b> to <b>18 MARCH 19 70</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>18 MARCH 19 70</b> and that in <b>(X)</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (do not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>3/20/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN, M.D.</b>				23D. ADDRESS <b>3900 LOCH RAVE BLVD BALTIMORE, MARYLAND 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/24/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto-National Cem.</b>	
24D. LOCATION (City, town or county) <b>5501 Frederick Ave. Md.</b>		24E. (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Walter E. Eickson - 137 (Carlin)</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650 70 3077		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3077	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CARRIE GREEN</b>		2. DATE AND HOUR OF DEATH <b>3/21/70 12:45 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co.</b>		5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Granada Nursing Home 4017 LIBERTY HGTS BALTIMORE MD 21207</b>		E. STREET AND NUMBER <b>1622 Hopewell ave</b>			
5. SEX <b>F</b>	6. RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/1/95</b>	9. AGE (in years last birthday) <b>95</b>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sparrows Point Md.</b>	
13. FATHER'S NAME <b>Fenton Brown</b>		14. MOTHER'S MAIDEN NAME <b>Eva</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Norman Green</b> ADDRESS	
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBROVASCULAR Accident</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Hemorrhage within brain</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Tuberculosis, dehydration, Unfed Decubiti</b>		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/13/70</b> 19 to <b>3/21/70</b> 19 that (I) (we) last saw the deceased alive on <b>3/21/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hollis Sewalline</b>		23B. DATE SIGNED <b>3/21/70</b>		23C. PHYSICIAN'S NAME (Type) <b>HOLLIS SEWALLINE</b>	
23D. ADDRESS <b>1801 Greenbury Rd 21209</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>Carver Memorial Park</b>		24D. LOCATION (City, town, or county) <b>Lund Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Milton E. Clifton</b>		ADDRESS <b>11297 [Signature]</b>	

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# FUNERAL DIRECTOR: IMPORTANT

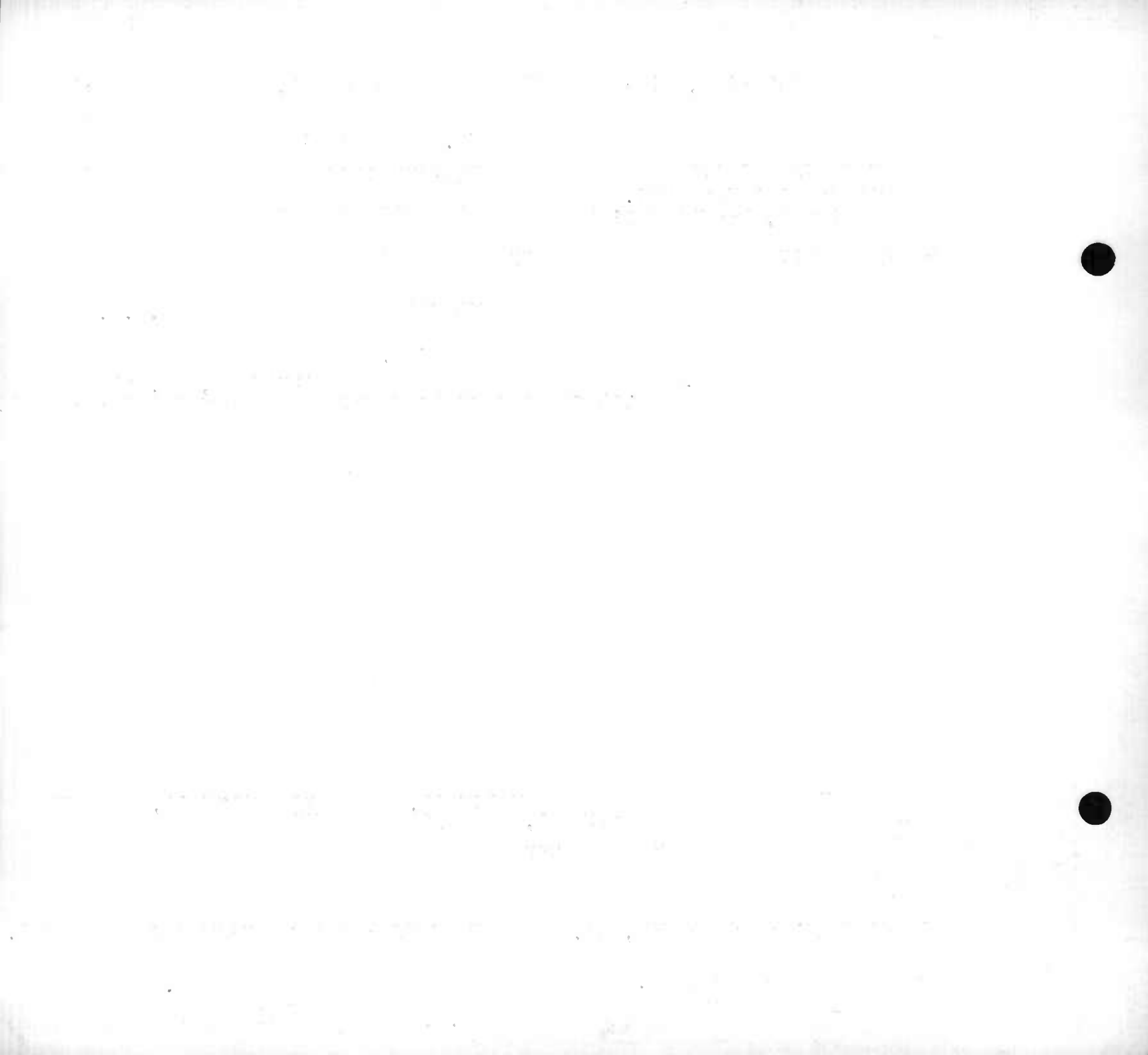
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 70 3078		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3078	
BIRTH NO. 70-04339		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY PEREZ JR.</b>		2. DATE AND HOUR OF DEATH <b>3/15/70 10:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GEN. HOSP.</b>		A. STATE <b>MD.</b>		B. COUNTY <b>BALTIMORE</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4108 8th St. Baltimore Md. 21225</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4108 8th St.</b>			
5. SEX <b>male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-70</b>	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>STEVE PEREZ</b>		14. MOTHER'S MAIDEN NAME <b>KAY LORD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>777X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity</b>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 14</b> 19 <b>69</b> to _____ 19____					
that (I) (we) last saw the deceased alive on _____ 19____ and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>3/15/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		23D. ADDRESS <b>South Baltimore Gen Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3-20-70</b>		24C. NAME OF CEMETERY or CREMATOR <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		70 3079	
BIRTH NO.				70 3079		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SHEPPARD, IDA ELLEN				MARCH 21, 1970		7:15P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
40 ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229				MD. HOWARD		6300	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				8198 MAIN STREET			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		09 09 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife				MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
late John Sheppard				MARY E.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				214 54 9105		BALTIMORE, MD. ADDRESS 21229 ST AGNES RECORDS WILKENS & CATON AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cardio Vascular accident		2 wks.	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				(C) Chronic bilateral Hygroma			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
13-19-70		Subacute Hygroma bilateral		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from MARCH 17, 19 70 to MARCH 21, 19 70 that (1) (we) lost saw the deceased alive on MARCH 21, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Ponnampalam Sabanayagam				3/21/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PONNAMPALAM SABANAYAGAM, MD.				ST AGNES HOSPITAL WILKENS & CATN AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		March 25 70		St. Johns		Ellicott City Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 24 1970		Robert E. Taylor, Jr.		Howard County		Fun. Home Harry Witzke Ellicott City	



R-340

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

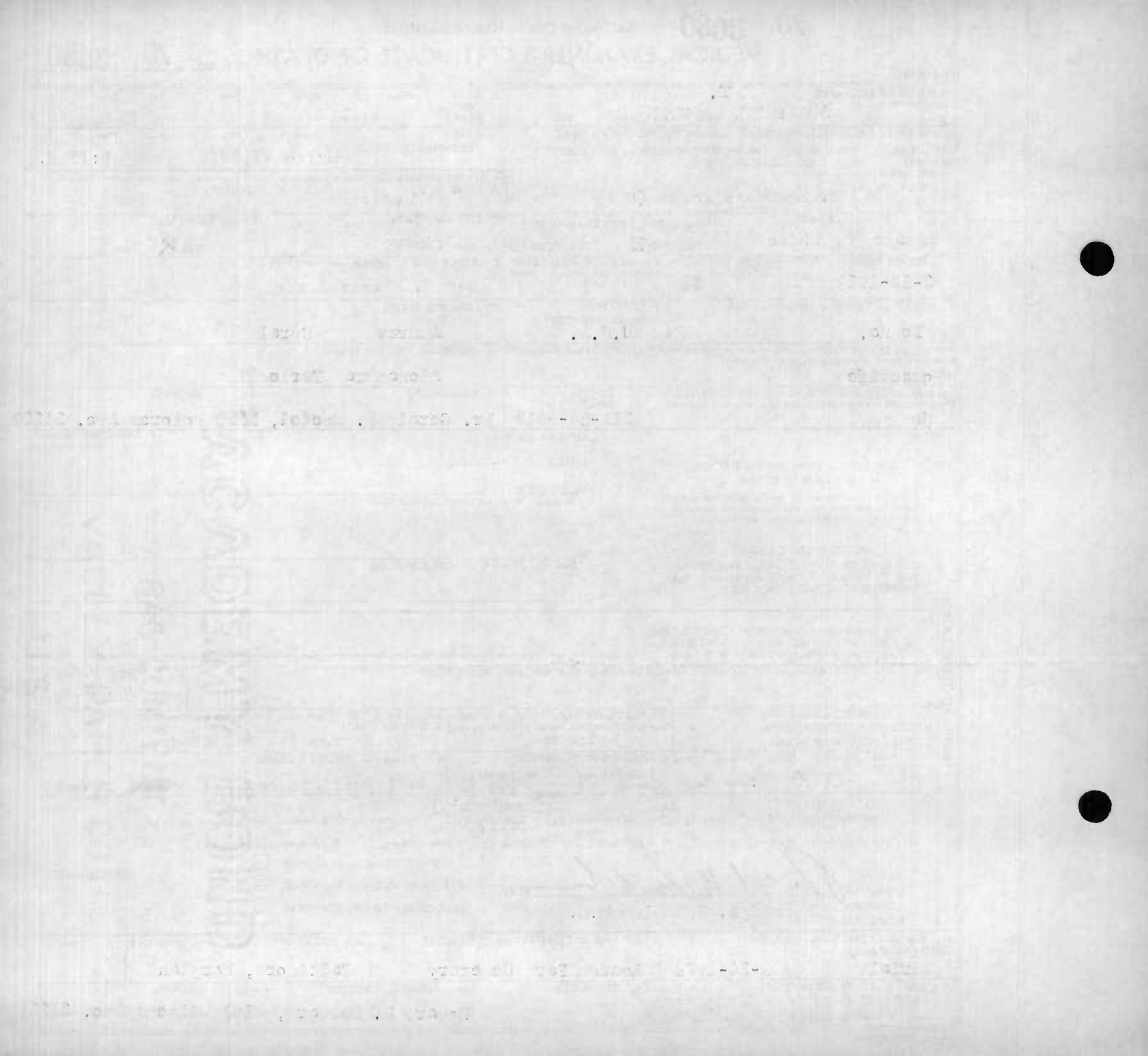
REG. NO.

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3080

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE ROEDEL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 343 S. Monroe Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 1:15 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-18-1914</b>		10. AGE (In years last birthday) <b>56</b> # Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-34-9419</b>	
18. INFORMANT <b>Mr. Gerald M. Roedel, 5550 Dolores Ave. 21227</b>		ADDRESS	
19. <b>E956X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of head</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bedroom</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>343 S. Monroe St, 2nd floor 1903</b>		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) <b>3-21-70 1:00 P.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Self-inflicted gunshot wound of head</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>3/22/70</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-24-1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	



1. NAME OF DECEASED (Type or Print) <b>DELORES J. ECKART</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 9:40 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2553</b>	
9. DATE OF BIRTH <b>2-21-1970</b>		10. AGE (In years last birthday) <b>4 weeks</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward A. Eckart</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>	
15. MOTHER'S MAIDEN NAME <b>Delores A. Sims</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mr. Edward A. Eckart, 1801 Sexton Street 21230</b>	
19. <b>795X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Sudden death in infancy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (b) DUE TO, OR AS A CONSEQUENCE OF:  (c) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>3/22/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-24-1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Washington Blvd., Howard Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	



STATE OF NEW YORK

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1. NAME OF DECEASED (Type or Print) <b>LEON PRICE, SR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1920 W. Pratt Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-1-1906</b>		10. AGE (in years lost birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Price</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
15. MOTHER'S MAIDEN NAME <b>Mary E. Murill</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>213-10-2481</b>		18. INFORMANT <b>Mrs. Dorothy E. Schneider, 8533 Harris Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>3-25-1970</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		DATE SIGNED <b>3/22/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Sabin</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	

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BIRTH NO.		70 3083		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3083	
1. NAME OF DECEASED (Type or Print) EUGENE L. BRENNAN				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL				3. DATE PRONOUNCED DEAD March 21, 1970		Month Day Year		Hour M. 2:10 P.	
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-15-1902				10. AGE (In years lost birthday) 68		11. BIRTHPLACE (State or foreign country) Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John T. Brennan		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Master		15. MOTHER'S MAIDEN NAME Agnes B. Kraining	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 215-01-1601		18. INFORMANT Mr. Andrew J. Brennan, 1645 Lyle Ct.		ADDRESS 21234	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.44-250.0				CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
				Diabetic Acidosis					
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				DATE SIGNED 3/22/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-1970		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229			

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STANDARD BANKING CORPORATION

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-200 70 3084</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3084</u>	
1. NAME OF DECEASED (Type or Print) <u>Hook, Thomas M.</u>				2. DATE AND HOUR OF DEATH <u>3-22-70 1:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles Gen. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2788</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5239 Reisterstown Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-03</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas S. Hook</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213102981</u>		17. INFORMANT <u>Mr. John W. Hook, 1086 Edinboro Road</u> <u>North Charles Chart</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.11</u> [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Rt Lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> 19 <u>70</u> to <u>3-22</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Cassino Sr. M.D.</u>				23B. DATE SIGNED <u>3-22-70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>M. Cassino - M.D., M.D.</u>				23D. ADDRESS <u>North Charles Gen. Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-25-1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>H. H. Halliday</u> ADDRESS <u>5. H. 4107 Wilkins Ave.</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-100		70 3085		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 70 3085	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TAAFE ALMA M.</b>		2. DATE AND HOUR OF DEATH <b>3/22/70 3<sup>35</sup> A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MD HOSPITAL 38 HOSPITAL</b>				A. STATE <b>MD</b>		B. COUNTY <b>BALTIMORE</b>		5200	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>280 E. Stanley Terr. Baltimore MD</b>					
5. SEX <b>Female</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-30</b>	9. AGE (In years last birthday) <b>40</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK MANAGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HARLEY'S SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>JAMES SMITH</b>				14. MOTHER'S MAIDEN NAME <b>Bessie M Hartman</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph R Taafe 280 E Stanley Ter 21225</b>		ADDRESS			
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Insufficiency</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>A.S.V.D</b> DUE TO, OR AS A CONSEQUENCE OF:		—			
				(C) <b>Post-op Anuria</b>		<b>5</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>Portic (abdominal) Endarterectomy</b>		<b>6</b>			
19A. DATE OF OPERATION <b>3/17/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Occlusion of abdominal aorta</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3/14/70</b> 19 to <b>3/22</b> 1920 that (I) (we) lost saw the deceased alive on <b>3/22/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Abraham C. Karas</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/22/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM C. KARAS</b>				23D. ADDRESS <b>UNI OF MD. HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Co Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>McCully FH 237 Potomac Ave</b>		25D. ADDRESS <b>2422 V5</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

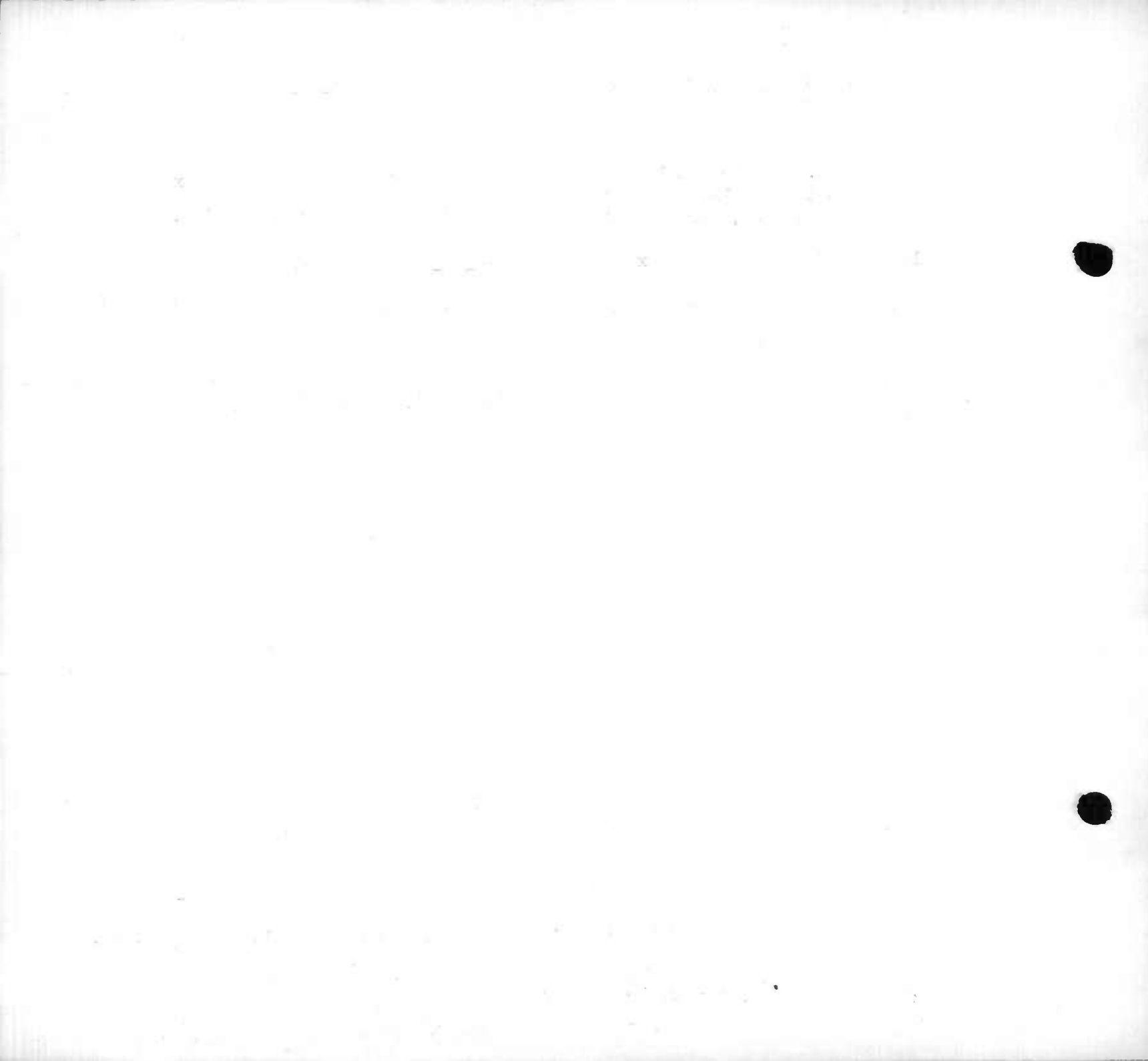
G-632 70 3086		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3086	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ROBERT GRETZNER</b>		2. DATE AND HOUR OF DEATH <b>3-20-70 7:45p. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore Genl Hosp.</b> <b>43</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2504 W. Patapsco Ave #30</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-17-01</b>	9. AGE (in years last birthday) <b>68</b>	If Under 1 To Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Modern Trash Removal</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John R. Gretzner</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Rausch</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>2-12-05-9182-A</b>		17. INFORMANT <b>Daughter</b> (as above)	
18. <b>441.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Acute alcoholic Del. Tremor</b>		(A) IMMEDIATE CAUSE <b>Pulmonary Edema; Congestion</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Resisting Anesthesia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> <b>3 day</b> <b>6 hr</b>	
19A. DATE OF OPERATION <b>3-16-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SERIOUS</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>home</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>March 16 1970</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>March 16 1970</b> to <b>March 20 1970</b> that (I) (we) lost saw the deceased alive on <b>March 20 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ABANDO NAPOLCON</b>		23B. DATE SIGNED <b>3-20-70</b>		23C. PHYSICIAN'S NAME (Type) <b>ABANDO NAPOLCON</b>	
23D. ADDRESS <b>SOUTH BALT. GEN. HOSP.</b>		23E. DATE <b>3-23-70</b>		23F. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23G. LOCATION <b>Baltimore, Maryland</b>		23H. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		23I. NAME OF REGISTRAR <b>John C. Miller</b>	
23J. FUNERAL DIRECTOR <b>John C. Miller</b>		23K. ADDRESS <b>Imc-6415 Belair Rd. -21206</b>		23L. DATE <b>3-23-70</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-322 70 3087		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3087	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Stanley (Stanislaw) STYCZEWSKI		2. DATE AND HOUR OF DEATH 3-21-70 4:29 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2505		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 4703 Fairhaven Avenue, Balto. 21226	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-92	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCTION		10B. KIND OF BUSINESS OR INDUSTRY ASPHALT CO		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 313 054035A		17. INFORMANT 1319 Church ST. DANIEL RZEPEKOWSKI - BALTO, 212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Posterior myocardial infarction 2 days (B) Occlusion, Coronary Artery DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) Stenosis Obesity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21 1970 to 3-21 1970 that (I) (we) last saw the deceased alive on 3-21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George S. Patrick		23B. DATE SIGNED 3-21-70		23C. PHYSICIAN'S NAME (Type) GEORGE S. PATRICK, M.D.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3/24/70		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR John H. Heine		24F. FUNERAL DIRECTOR Baltimore 21226	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

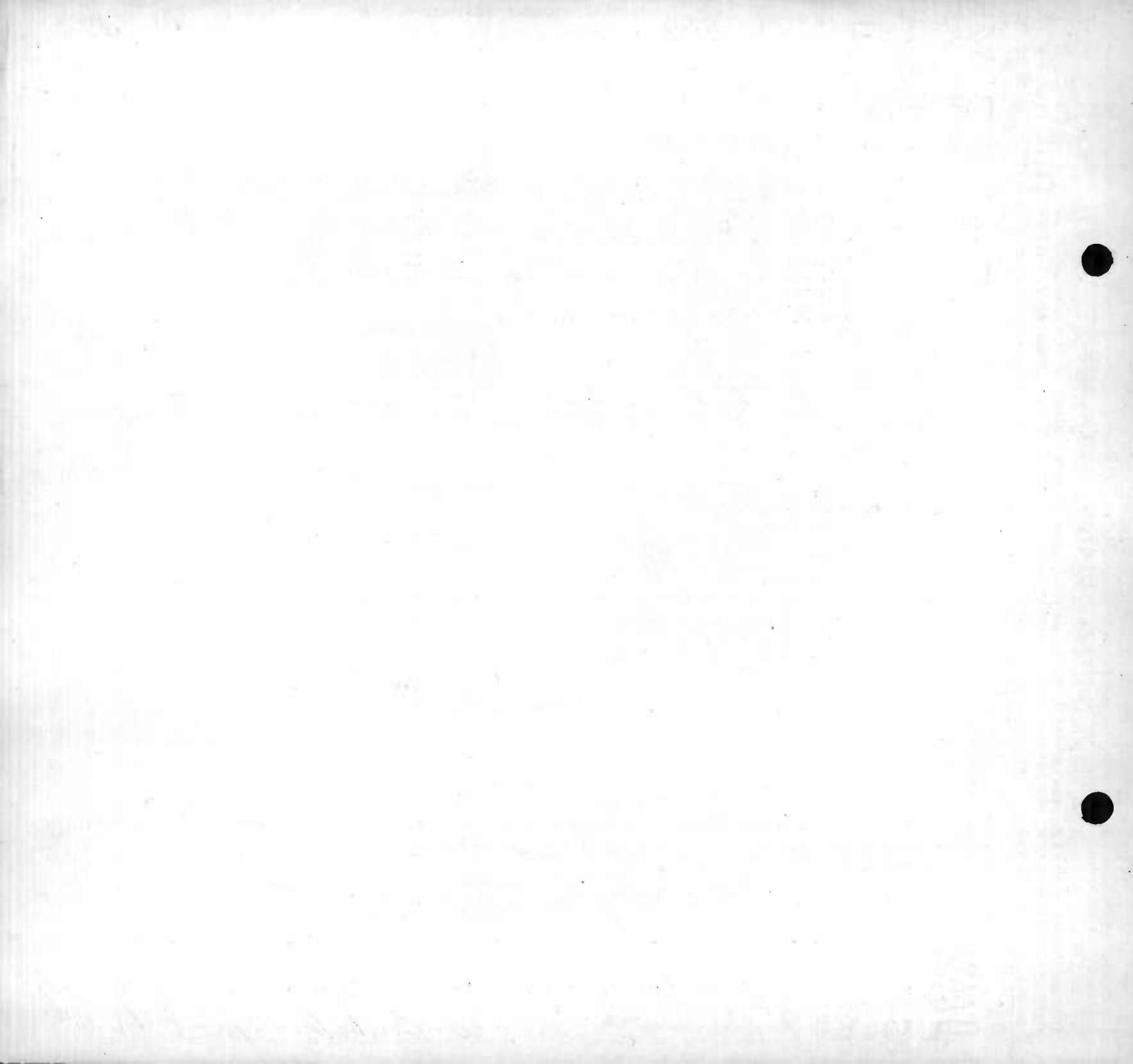
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.	
B-650 70 3088		70 3088		70 3088	
1. NAME OF DECEASED (Type or Print) <b>Brown, Helen</b>		2. DATE AND HOUR OF DEATH <b>3-18-70 9:00 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>5 CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>DALTON</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Rt. 2 Box 217 Arnold M.D. 21012</b>			
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-1-01</b> 9. AGE (in years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		13. FATHER'S NAME <b>William Fox</b>		14. MOTHER'S MAIDEN NAME <b>Auraelia Bronner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-30-0974</b>		17. INFORMANT <b>Husband</b> ADDRESS <b>Rt. 2 Box 217 Arnold</b>	
18. <b>1924</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic neurofibrosarcoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intestinal obstruction</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>21-19-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>3-17-70</b> to <b>3-18-70</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.					
23A. SIGNATURE <b>A. Madarang Jr. M.D.</b>				23B. DATE SIGNED <b>3-18-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALFONSO A. MADARANG M.D.</b>				23D. ADDRESS <b>5505-E Sarril Rd Baltimore Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-21-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>	
25B. NAME OF REGISTRAR <b>Wm. F. Tickner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>North Penn</b>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-656		70 3089		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3089	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Charles Kraemer, Sr.			
2. DATE AND HOUR OF DEATH 3/22/70 3:15 a.m.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN EDGEMERE	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 2344 Ruth Avenue 21219		5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-19		9. AGE (In years last birthday) 50		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL MFGGR.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles				14. MOTHER'S MAIDEN NAME Laura Mason			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 214-16-7787		17. INFORMANT ADDRESS 4940 Eastern Avenue BCH Records- Baltimore, Maryland 21224			
18. 340X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia (B) multiple sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32. 10 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/4 1970 to 3/22 1970, that (I) (we) last saw the deceased alive on 3/22 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J.R. Neefe, M.D.				23B. DATE SIGNED 3/22/70		23C. PHYSICIAN'S NAME (Type) J.R. Neefe, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-25-70		24C. NAME of CEMETERY or CREMATORY BELAIR MEM. GRD.		24D. LOCATION (City, town, or county) (State) BELAIR, HARTFORD CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS W. [Signature]			





# FUNERAL DIRECTOR: IMPORTANT

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C-552		70 3090		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		GERTRUDE CUNNINGHAM		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		GERTRUDE CUNNINGHAM		2. DATE AND HOUR OF DEATH 3-20 PM March 20, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD		B. COUNTY 2403	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 105 Warren Ave	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 22, 88	9. AGE (in years last birthday) 81 yrs	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern		10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph Cunningham		14. MOTHER'S MAIDEN NAME Mary Fitzpatrick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 219-32-0645-A		17. INFORMANT Gertrude Hulseman 1253 Carroll St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 180 X Extensive Ca. Cervix E distant metastases DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION O X		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED X		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1, 70 to March 20, 1970 that (I) (we) last saw the deceased alive on March 20, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE gwl		23B. DATE SIGNED March 20, 70		23C. PHYSICIAN'S NAME (Type) DR. GOLO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-23-70		24C. NAME of CEMETERY or CREMATORY BALTIMORE	
24D. LOCATION (City, town, or county) (State) BAL TO. MD.		24E. NAME of REGISTRAR Rabert E. Baker, Md.		24F. FUNERAL DIRECTOR KRAUSE FUNERAL HOME-1216 S. CHARLES ST.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



## FUNERAL DIRECTOR: IMPORTANT

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H-156		70 3091		BALTIMORE CITY HEALTH DEPARTMENT		70 3091	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Richard Heffner				2. DATE AND HOUR OF DEATH 3-21-70 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland		B. COUNTY Baltimore	
C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 946 Lance Avenue 21221			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-29-18	9. AGE (in years last birthday) 51	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William				14. MOTHER'S MAIDEN NAME Roda			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 165-18-2995		17. INFORMANT 4940 Eastern Avenue BCH Records- Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410191 CAUSE OF DEATH CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE PROBABLE MYOCARDIAL INFARCTION (B) ASCID (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/21/70 to 3/21/70 and that (I) (we) last saw the deceased alive on 3/21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jaime F. Casellas				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/25/70		24C. NAME OF CEMETERY OR CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR Robert C. Taylor		25C. FUNERAL DIRECTOR Cornell Funeral Home		25D. ADDRESS 300 York Ave	

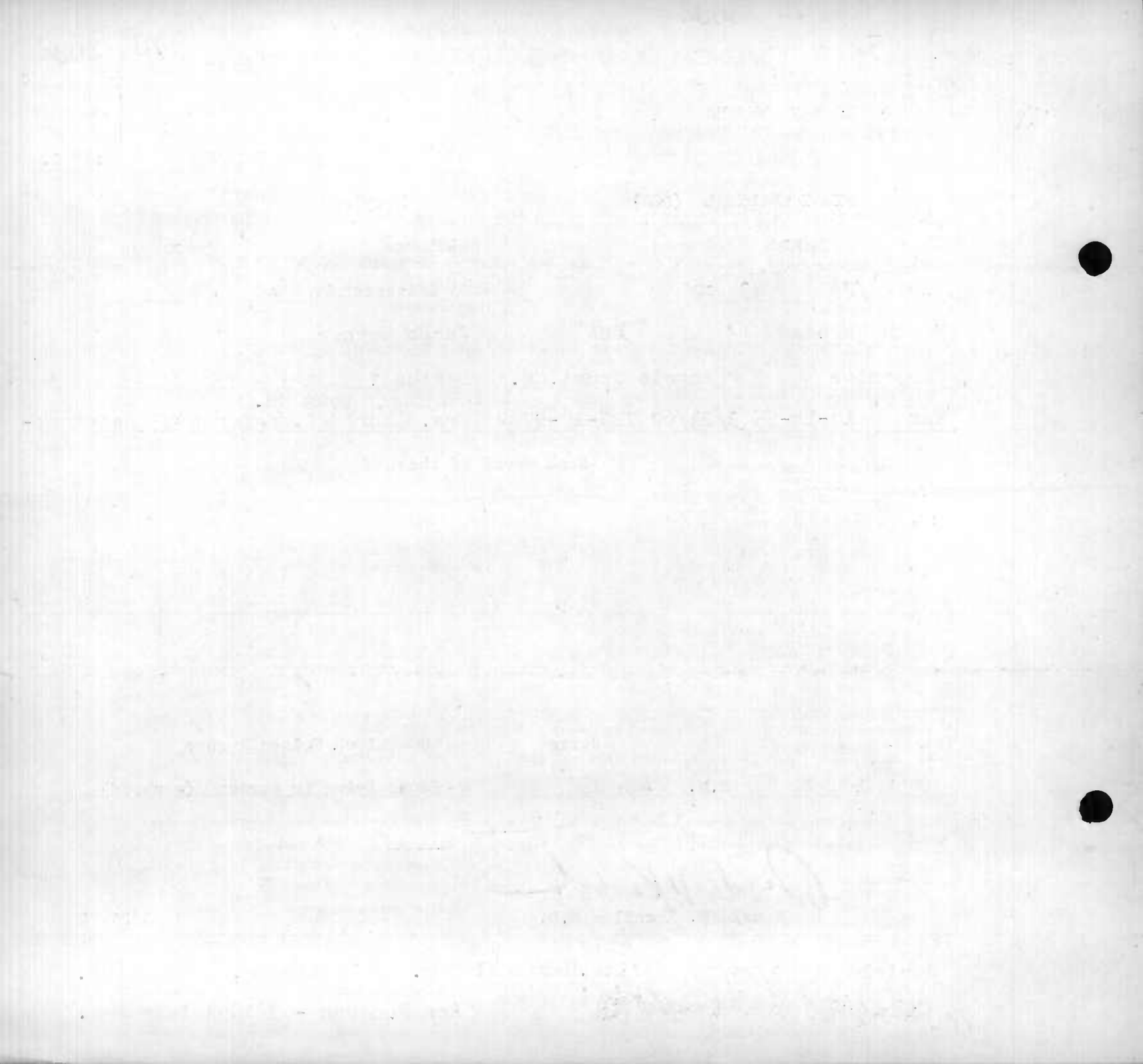


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT WEGNER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 9:40 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/23/26</b>				10. AGE (In years lost birthday) <b>43</b>		11. BIRTHPLACE (State or foreign country) <b>North Dakota</b>	
12. CITIZEN OF <b>USA</b>				13. FATHER'S NAME <b>Jacob Wegner</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>Angelo Const.Co.</b>			
15. MOTHER'S MAIDEN NAME <b>Hertha ?</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10-18-55 3/21/62</b>			
17. SOCIAL SECURITY NO. <b>725-10-4709</b>				18. INFORMANT <b>town Rd.</b>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E9661 X</b>				CAUSE OF DEATH <b>Stab wound of chest</b>			
20. DATE OF OPERATION <b>2</b>				21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4800 block Nelson Avenue</b>				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>3-20-70 P.M.</b>			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Found lying in street (stabbed)</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. DATE <b>3/25/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>			
24C. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				24D. FUNERAL DIRECTOR <b>Ann Donovan - 3818 Roland Ave.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>				25B. NAME OF REGISTRAR <b>W. J. S. Kelly, M.D.</b>			
25C. NAME OF REGISTRAR <b>W. J. S. Kelly, M.D.</b>				25D. ADDRESS <b>Ann Donovan - 3818 Roland Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3093</b>	
<b>M-623 70 3093</b>		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARSTON, Ralph Lester</b>		2. DATE AND HOUR OF DEATH <b>3-20-70 12:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1305</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2900 Keswick Road</b>	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-27-09</b>	9. AGE (In years last birthday) <b>60</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Carlyle Apts.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Marvin Marston</b>		14. MOTHER'S MAIDEN NAME <b>Elma Bortle</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10-28-43 to 1-28-46</b>		16. SOCIAL SECURITY NO. <b>216-07-64-36</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>	
18. <b>143.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION PNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA POSTERIOR AVELORA RIDGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>March 2,</b> 19 <b>70</b> to <b>March 20,</b> 19 <b>70</b> , that <b>HD</b> (we) last saw the deceased alive on <b>March 20,</b> 19 <b>70</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. ( <b>X</b> (We) (did) ( <b>DOES</b> view the body after death.					
23A. SIGNATURE <b>W. Smithwick, M.D.</b>		23B. DATE SIGNED <b>3-20-70</b>		23C. PHYSICIAN'S NAME (Type) <b>WALTER SMITHWICK M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		23E. NAME OF REGISTRAR		23F. FUNERAL DIRECTOR <b>Ann Donovan - 3818 Roland Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Good Shepherd Cemetery</b>	
24D. LOCATION <b>Howard Co.,</b>		24E. STATE <b>Md.</b>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Ann Donovan - 3818 Roland Ave.</b>	

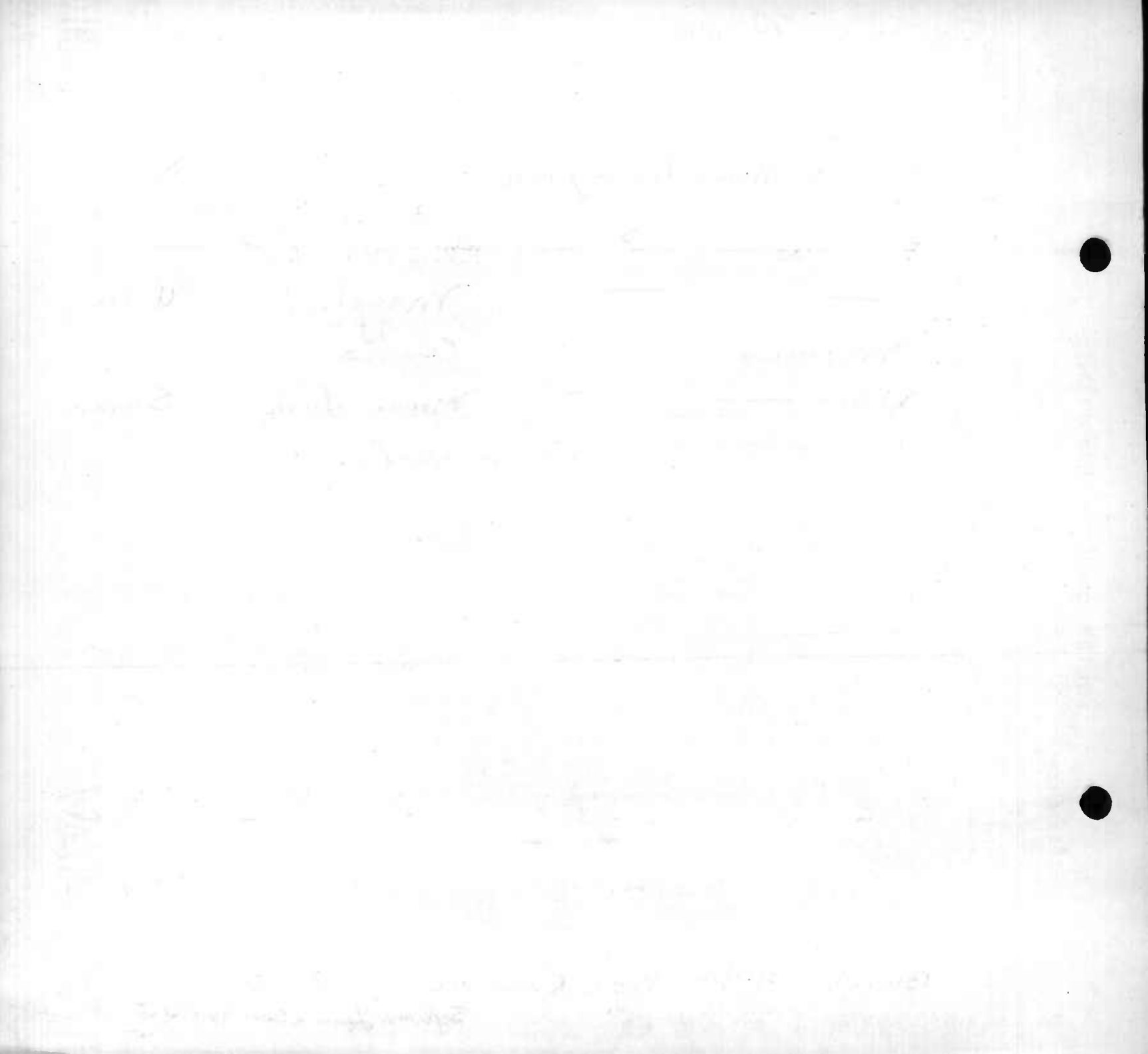




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-532 70 3094				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3094	
1. NAME OF DECEASED (Type or Print) <b>DORIS J. LUNTZ</b>				2. DATE AND HOUR OF DEATH <b>3/20/70 3:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Pleasant Manor Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>21215</b> C. CITY OR TOWN <b>Balto md</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3301 Clarks Lane</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 10, 1905</b>		9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Morris</b>				14. MOTHER'S MAIDEN NAME <b>Anna</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Morris Luntz</b>		ADDRESS <b>Same</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH <b>Carcinoma, Breast</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-18 1970</b> to <b>3-20 1970</b> , that (I) <del>was</del> last saw the deceased alive on <b>3-19 1970</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Frank J. Kurlander MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/20/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/22/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Riga Kurlander</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Blaise J. ...</b>		25C. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son 9610 Reisterstown Rd</b>			



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W-000 70 3095  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 70 3095

1. NAME OF DECEASED (Type or Print) <b>LAKE MING WU</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 8:45 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Yellow</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 24, 1897</b>		10. AGE (in years lost birthday) <b>72</b>	
11. BIRTHPLACE (State or foreign country) <b>CHINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>YES WW II</b>		17. SOCIAL SECURITY NO. A <b>123-07-8160A</b>	
15. MOTHER'S MAIDEN NAME <b>Su - San Sun</b>		18. INFORMANT: (wife) <b>Pearl Stokes Wu, 222 N. Liberty St., City</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.41</b>		CAUSE OF DEATH <b>Intracerebral hemorrhage</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>3/22/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Mar. 25, 1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville, (Balto.), Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>		ADDRESS <b>108 W. North Av., City</b>	

ACADEMIC (310111)

RAO (001111)

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3096

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Martha A. Brown</b>		2. DATE OF DEATH Known <input type="checkbox"/> 3 Month Day Year Estimated <input type="checkbox"/> 20 70 510 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 540 St. Mary Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 5:10 P. M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1701</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>7-5-1903</b>		10. AGE (In years last birthday) <b>66</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	E. STREET AND NUMBER <b>540 St. Mary Street</b>
13. FATHER'S NAME <b>John O. Mason</b>		14. MOTHER'S MAIDEN NAME <b>Martha Robinson</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		16. KIND OF BUSINESS OR INDUSTRY <b>U. of Md. Law School</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>Fannie Bland - 540 St. Mary St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>199.01</b> <b>Carcinomatosis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
22A. DATE OF OPERATION <b>0</b>		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?		22H. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an <u>Inquiry</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
25. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		26. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
27. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		28. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
29. DATE SIGNED <b>3/21/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-24-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		25D. ADDRESS <b>802 Madison Ave.</b>	

WALLACE PAPER

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3097

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RUDOLPH RANDOLPH LANCASTER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PROVIDENT HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1970 8:45 P.M.</b>			
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8-16-1930</b>		10. AGE (In years lost birthday) <b>39</b>		E. STREET AND NUMBER <b>1057 Ellicott Drive</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Lancaster</b>		15. MOTHER'S MAIDEN NAME <b>Edith Peace</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housing Authority</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8-29-47 - 1-13-50</b>			
17. SOCIAL SECURITY NO. <b>219-22-8235</b>		18. INFORMANT <b>Mildred Lancaster - 1057 Ellicott Drive</b>				ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E-9651</b> <b>Gunshot wound of chest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Rear of 630 N. Carey Street 1602</b>			
22D. TIME OF INJURY (APPROX.) <b>3-20-70 8:30 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Gunshot wound of chest</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/21/70</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore, National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law 802 Madison Ave.</b>			

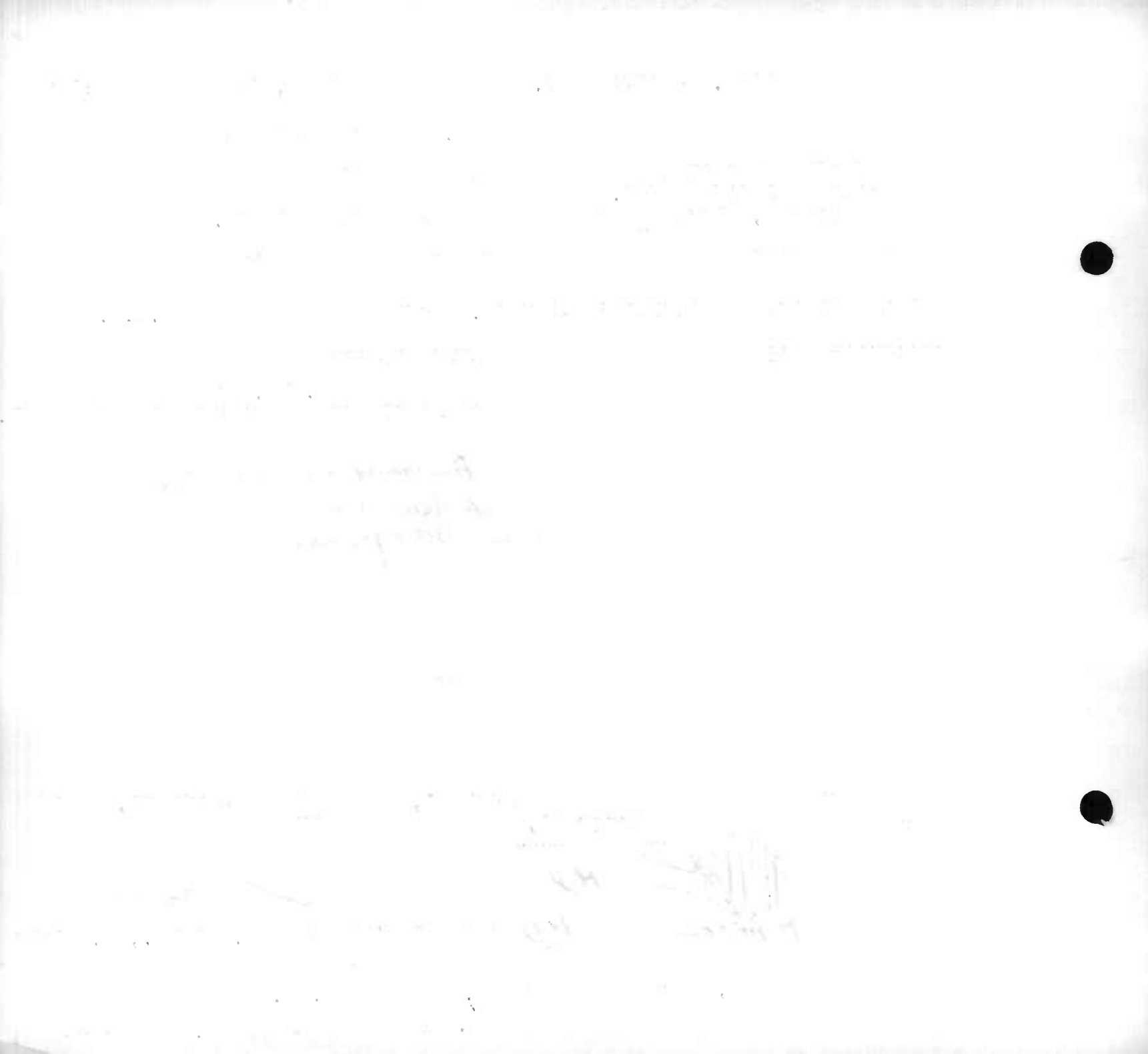




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		70 3098		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3098	
1. NAME OF DECEASED (Type or Print) MAIER, CHRISTIAN C.				2. DATE AND HOUR OF DEATH MARCH 21, 1970 7:15P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL 5200 C. CITY OR TOWN SEVERNA PARK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 247 ARUNDEL BEACH RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 25 28	9. AGE (In years last birthday) 41	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER				10B. KIND OF BUSINESS OR INDUSTRY MARVELITE PAINT CO. MARYLAND			
13. FATHER'S NAME CHRISTIAN MAIER				14. MOTHER'S MAIDEN NAME MARY BARRICK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220248316		17. INFORMANT BALTO. MD. 21229 ST AGNES RECORDS WILKENS & CATON AVES.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ac Cerebroreticulium cord (B) Gas gangrene DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from MARCH 21, 19 70 to MARCH 21, 19 70 that (X) (we) last saw the deceased alive on MARCH 21, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE M. Afzal 23B. DATE SIGNED 3-22-70 23C. PHYSICIAN'S NAME (Type) M. Afzal 23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE March 23, 24 1970 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. 24D. LOCATION Balto. Md. 25A. DATE RECEIVED BY HEALTH DEPARTMENT MAR 24 1970 25B. REGISTRAR Robert E. Schab 25C. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike ADDRESS							



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3099

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES BOONE</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>March</u> Day <u>19</u> Year <u>1970</u> Estimated <input type="checkbox"/> Hour <u>6:40</u> A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u>				3. DATE PRONOUNCED DEAD Month <u>March</u> Day <u>19</u> Year <u>1970</u> Hour <u>6:40</u> A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1402</u>					
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <u>April 15, 1914</u> <u>55</u>		10. AGE (In years last birthday) <u>55</u>		E. STREET AND NUMBER <u>626 W. Lafayette Avenue</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Henry Boone</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Sallie Dailey</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <u>212-18-3838</u>		18. INFORMANT ADDRESS <u>Mildred Edmonds 214 1st. St. Weldon N.C.</u>	
19. <u>412.2 + E 814.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Multiple injuries</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Intersection of 600 W. Lafayette Ave. &amp; Shields Place</u>	
22D. TIME OF INJURY (APPROX.) <u>3 16 70 8:50 A.M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Pedestrian struck by auto</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>March 19, 1970</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/24/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Margaretta B. Brown 3106 Walbrook Ave.</u>	

Letter from M.E.'s office

5-22-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-526 70 3100		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 70 3100	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>RALPH N. SHOEMAKER</u>			
2. DATE AND HOUR OF DEATH <u>March 20 1970 255P.M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HOUSE IN THE PINES</u> <u>102525 W. BELVEDERE AVE BALTIMORE Md.</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>WASHINGTON</u>				C. CITY OR TOWN <u>HAGERSTOWN</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>125 N. PROSPECT STREET</u>				5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7-6-1906</u> 9. AGE (in years last birthday) <u>63</u>				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSEMBLER</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>NEWTON OLIVER SHOEMAKER</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE RAY MYERS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-3587</u>			
17. INFORMANT <u>Mrs Ralph N Shoemaker</u>				ADDRESS <u>FALLSTON MARYLAND</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aquaman cell Co of Long 670</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 19 1970</u> to <u>Mar 20 1970</u> that (I) (we) last saw the deceased alive on <u>Mar 20 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lester N. Kolman M.D.</u> 23B. DATE SIGNED <u>March 21, 1970</u>				23C. PHYSICIAN'S NAME (Type) <u>Lester N. Kolman, M. D.</u> 23D. ADDRESS <u>6821 Reisterstown Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>3-24-70</u> 24C. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u> 24D. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASHINGTON Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u> 25B. NAME OF REGISTRAR <u>J. J. J. J.</u> 25C. FUNERAL DIRECTOR <u>Charles M. Rouger</u> ADDRESS <u>Hagerstown Md.</u>			

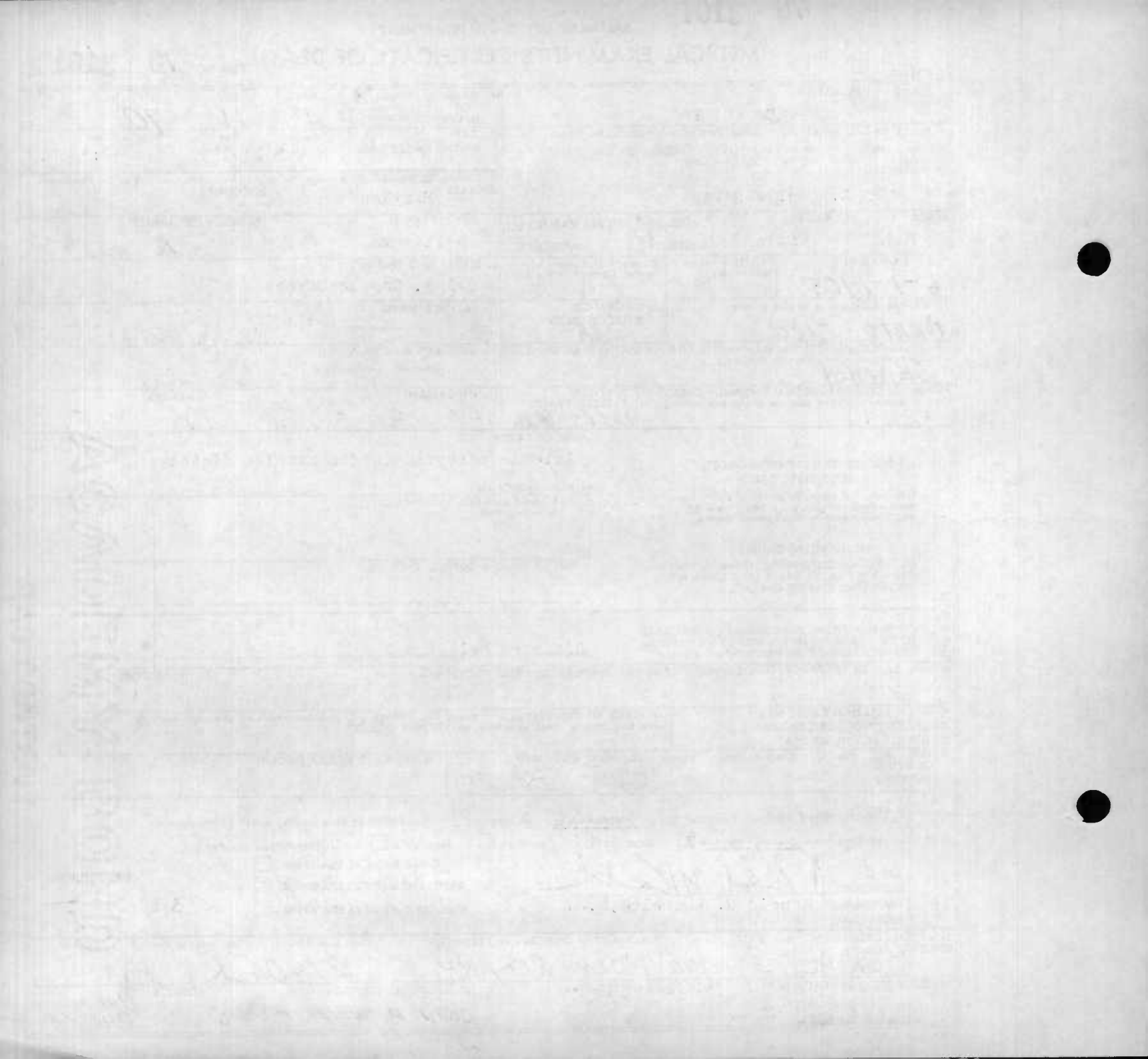


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3101

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GERARDO RIVERA</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 21 70 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00325 S. Castle Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 9:35 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6-1-1905</b>		10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>PUERTO RICO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>201</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMEN</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>123 07 846</b>		18. INFORMANT ADDRESS <b>DANIELA RIVERA 325 CASTLE ST.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.41 v-230.9</b> <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus</b>			
20A. DATE OF OPERATION <b>D</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/25/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY</b>		24D. LOCATION (City, town, or county) (State) <b>DUNDALK MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>John M. Weber &amp; Sons</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>401 S. CHESTER ST.</b>		DATE SIGNED <b>3/22/70</b>	

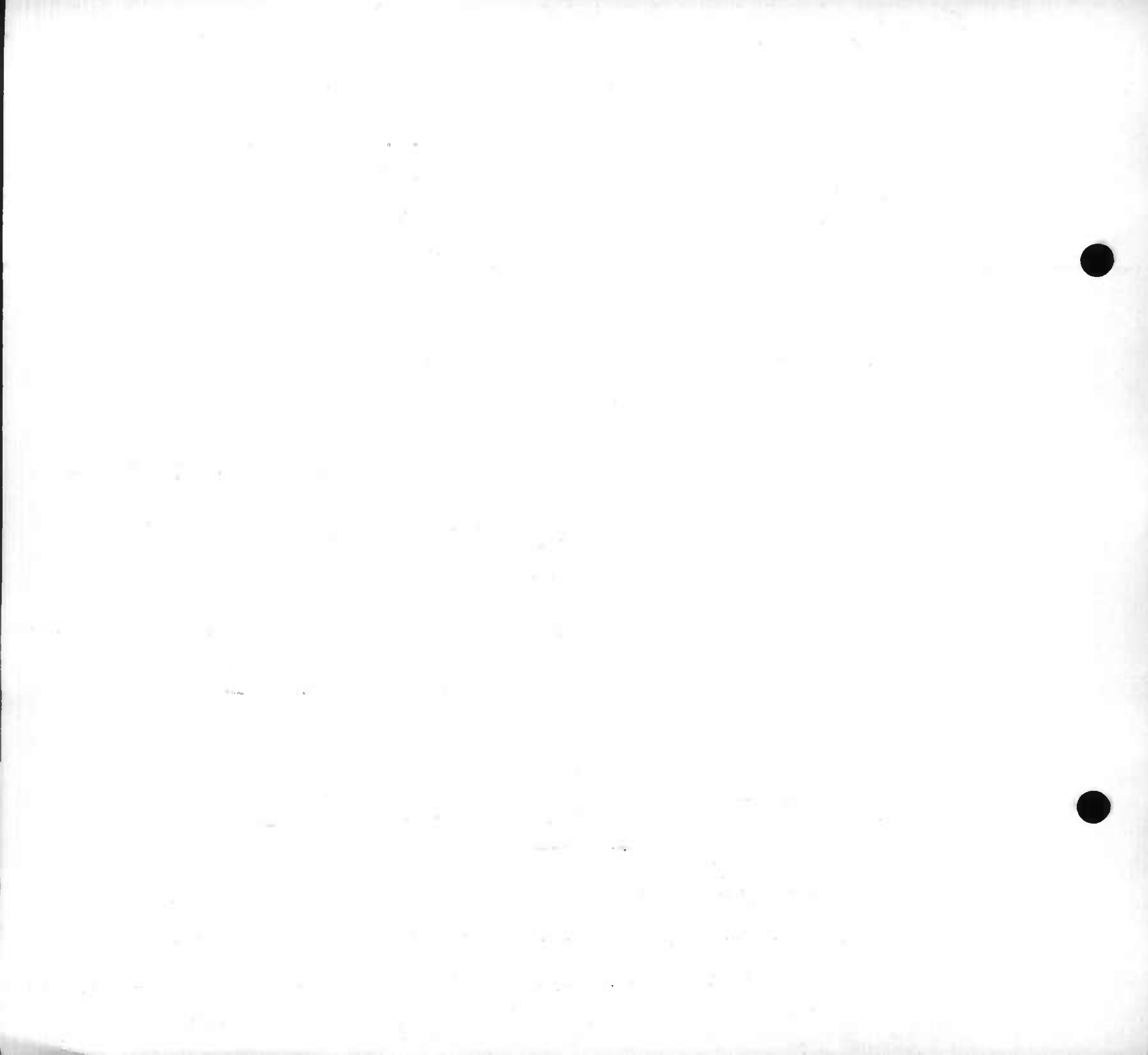




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		70 3102	
G-620 70-05564 70 3102				CERTIFICATE OF DEATH		REG. NO. 70 3102	
1. NAME OF DECEASED (Type or Print) <b>Gross, Baby Boy</b>				2. DATE AND HOUR OF DEATH <b>3/22/70 4:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>A.A.CO</b> B. COUNTY <b>MARYLAND</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 JOHNS HOPKINS 601 N. BROADWAY BALTO, MD 21205</b>				C. CITY OR TOWN <b>SEVERN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>RT# 1 BOX 214 B</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/70</b>		9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min. <b>11 25</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>FRED GROSS</b>				14. MOTHER'S MAIDEN NAME <b>BETTY GOINS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <b>776.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>aspiration pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>atelectasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>12 hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>respiratory acidosis, tension pneumothorax 4 hours</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) ( <del>this hospital</del> ) attended the deceased from <b>3/22</b> 19 <b>70</b> to <b>3/22</b> 19 <b>70</b> that (1) ( <del>we</del> ) last saw the deceased alive on <b>3/22</b> 19 <b>70</b> and that (in my) ( <del>last</del> ) opinion death occurred on the date and hour and from the causes stated above. (1) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>James W. Hanson M.D.</b>				23B. DATE SIGNED <b>3/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>James W. Hanson, M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins Hospital</b>		24D. LOCATION (City, town, or county) (State) <b>601 N. Broadway Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 3103 4	
CERTIFICATE OF DEATH		REG. NO. 56-49-91	
BIRTH NO. 70-04439		70 3103 4	
1. NAME OF DECEASED (Type or Print) Szoltyk, Baby Boy, Patricia		2. DATE AND HOUR OF DEATH 3-17-70 11:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2605	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 4940 Eastern Ave. Baltimore, Md. 21224 BALTIMORE CITY HOSPITALS		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-70 9. AGE (in years last birthday) 2 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven		14. MOTHER'S MAIDEN NAME Patricia Price	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH Records: Baltimore, Md		ADDRESS 4940 Eastern Ave 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory arrest 12 hrs (B) Respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF: (A) (B) (C) CNS Bleed 52 hrs (C) 8 hrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-15-70 to 3-17-70 that (I) (we) last saw the deceased alive on 3-17-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Mary Beale MD DEGREE		23B. DATE SIGNED 3/17/70	
23C. PHYSICIAN'S NAME (Type) Dr. M. Beale MD DEGREE		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md.. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-18-70 24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals 24D. LOCATION Baltimore, Maryland 21224 (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3104</span>	
B-650 5575 70 3104					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>ANNIE B JOHNSON (NEE) BROWN ANNA BELL</b>		2. DATE AND HOUR OF DEATH <b>6 P. M. 3-13-70</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND Hospital BALTIMORE, MARYLAND 21201</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3 NORTH CARLTON ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N. N.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-16-20</b>	9. AGE (In years last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARIE - DENNIS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chart</b> ADDRESS	
18. <b>394.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIAC ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>mitral valve disease, &amp;</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>open heart surgery</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>9-25-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>mitral valve disease</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-12-70</b> to <b>3-12-70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-12-70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rostern Fordin</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Rostern Fordin</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-17-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co.,</b>		24E. NAME OF REGISTRAR <b>Isaiah Brown and son</b>		24F. ADDRESS <b>102 W. Montgomery Street</b>	



W-452

70 3105

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3105

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

MELVIN EDWARD WILLIAMS

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

43 SOUTH BALTO. GENERAL HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 21, 1970

4:15 A.M.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2102

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☐NO ☐

## 9. DATE OF BIRTH

6/5/46

10. AGE (In years  
lost birthday)

23

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

## E. STREET AND NUMBER

723 Ramsey Street

## 11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Charles E. Williams

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Mable Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

219-40-2618

## 18. INFORMANT

## ADDRESS

Mable Williams 723 Ramsey St.

E9651X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Gunshot wound of head

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Peach Alley and Hamburg Street

2301

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

3-21-70 2:45 A.M. m.

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

## 22F. HOW DID INJURY OCCUR?

Gunshot wound of head

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/21/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

3/26/70

## 24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

## 24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

## 25A. DATE REC'D BY HEALTH DEPT.

MAR 24 1970

## 25B. NAME OF REGISTRAR

Charles E. Taylor, M.D.

## 25C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

WALLEY FOR

WALLEY FOR

WALLEY FOR

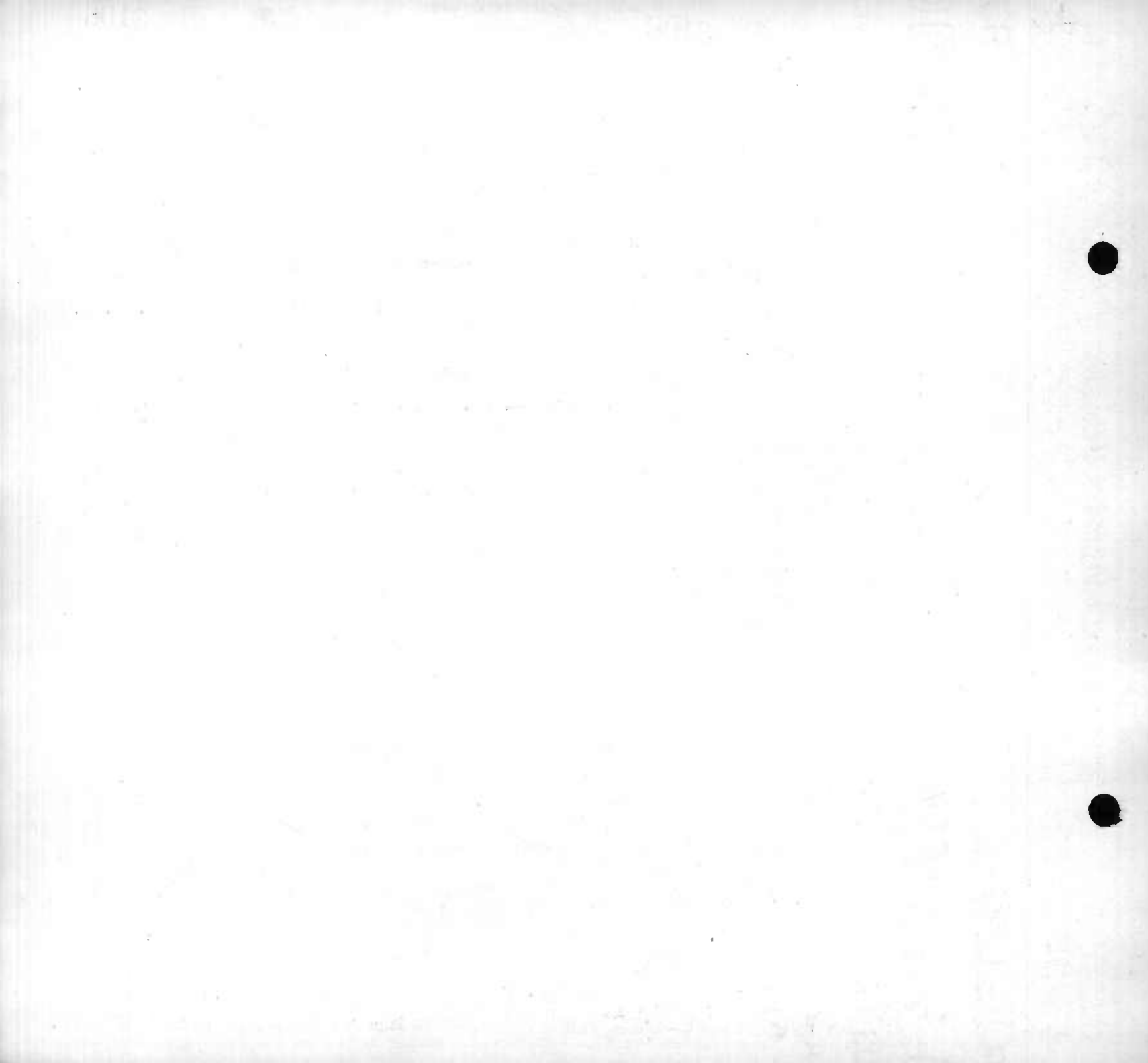
WALLEY FOR



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

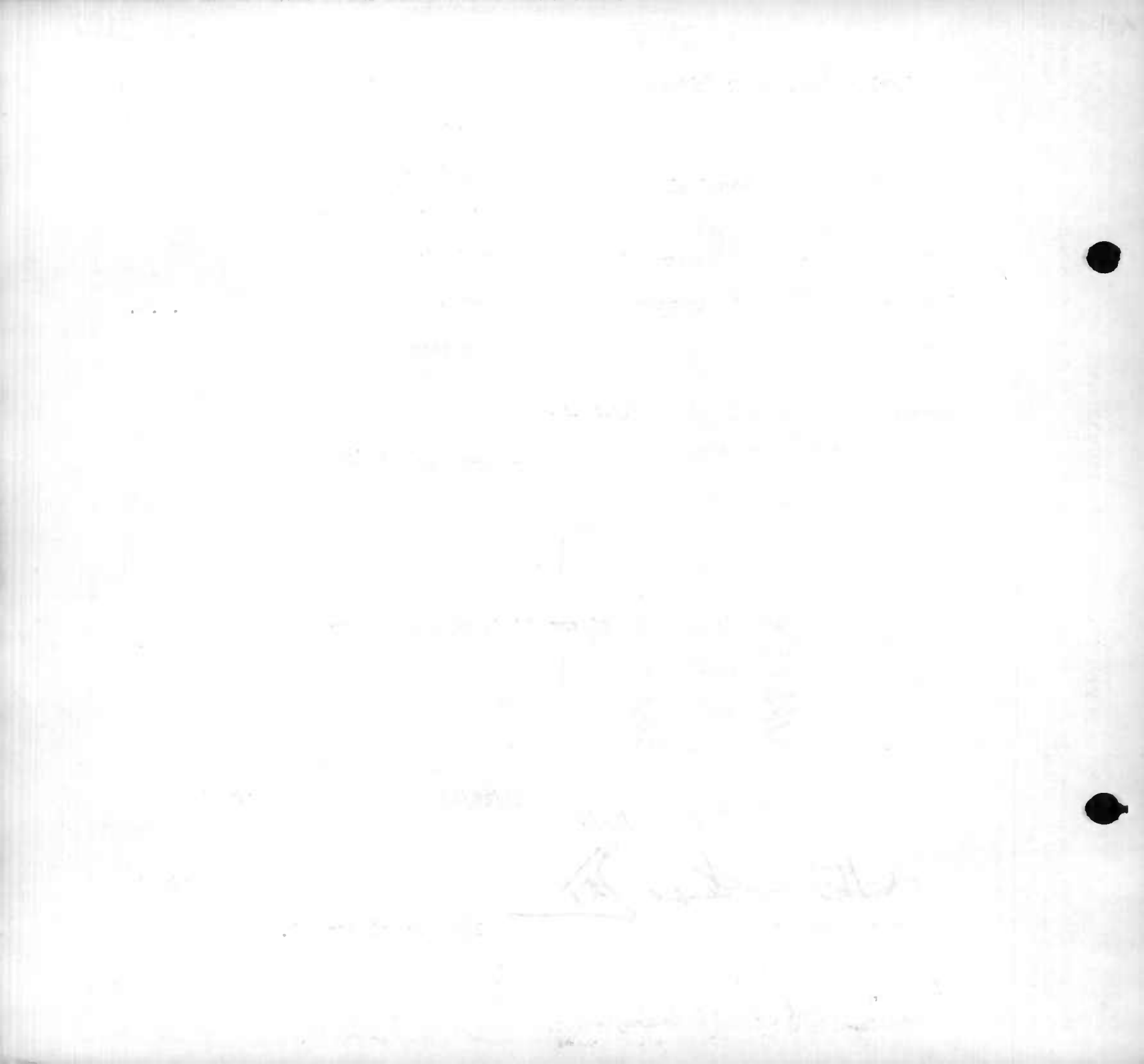
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3106</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3106</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ALICE PINDER</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-22-70 12.30 AM</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">33 JOHNS HOPKINS HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2302 McCULLOUGH STREET</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">C</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8-24-1900</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Cook</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Private Family</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Cambridge, Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Louis W. Boston</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary E. Campbell</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-26-7353-A</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Louis Hughes-2521 McCulloh Street</span>	
18. <span style="font-size: 1.5em;">410.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">MYOCARDIAL INFARCTION</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">ASCVD</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 hrs</span>  <span style="font-size: 1.2em;">10 years</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">GASTROINTESTINAL BLEEDING</span>			<span style="font-size: 1.2em;">3 WEEKS</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>it</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/1</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/22</span> 19 <span style="font-size: 1.2em;">70</span> , that <del>it</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/22</span> 19 <span style="font-size: 1.2em;">70</span> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Karl J. Kramer</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3/22/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">KARL J. KRAMER</span>		23D. ADDRESS <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">3-26-70</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Arbutus Mem. Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Co., Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 24 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Gibson Funeral Home-1631 Druid Hill Ave.</span>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>70 3107</b>	
BIRTH NO. <b>70 3107</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Charles MacAlester Johnson</b>		2. DATE AND HOUR OF DEATH <b>3/12/70 4:05</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>422 Pine Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>12/24/02</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>214-14-1979</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Osteomyelitis of left Femur</b>		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/28/67</b> to <b>3/12/70</b> and that (I) (we) lost saw the deceased alive on <b>3/12/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. <b>Hollis Seunarin</b>				23B. DATE SIGNED <b>3/12/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hollis Seunarin</b>				23D. ADDRESS M.D. <b>1801 Greenberry Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION <b>1212 W. North</b>		24E. CITY, TOWN, or COUNTY <b>Baltimore</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>1212 W. North</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

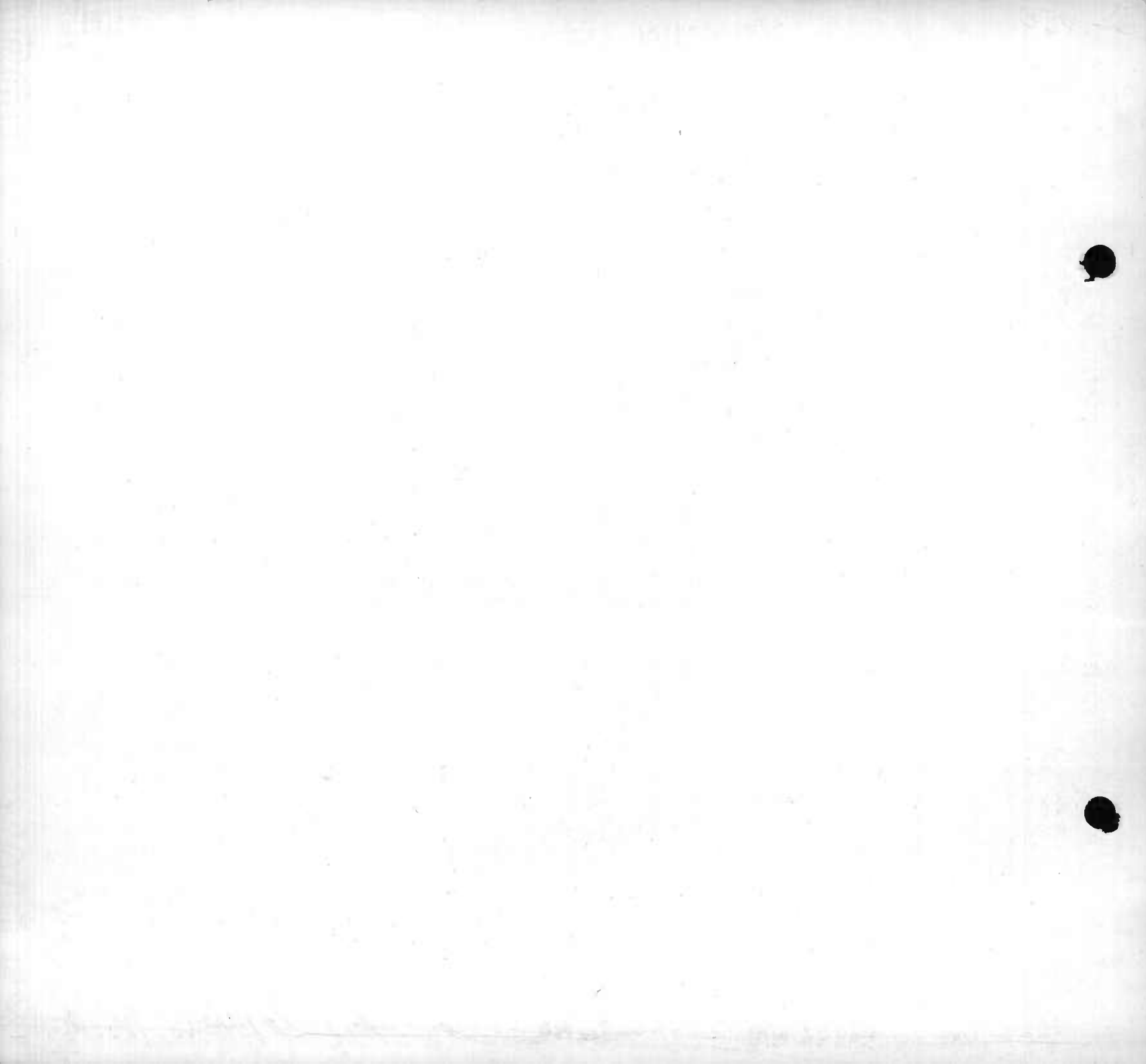
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3108	
70 3108				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Charles Matthews</u>		2. DATE AND HOUR OF DEATH <u>3/20/1970 2:30</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MA S. N. Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Nov. 25/1894</u>		9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes W.W.I</u>	
16. SOCIAL SECURITY NO. <u>214-03-6821</u>		17. INFORMANT ADDRESS <u>Jackie Bullock - 4820 G. Lane Drive</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>5-9-0-1-1</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pyloric stenosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>1 week</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pneumonia</u> <u>ASCO</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> 19 <u>70</u> to <u>3/20</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leon S. Sherr</u> M.D. DEGREE		23B. DATE SIGNED <u>3/24/70</u>		23C. PHYSICIAN'S NAME (Type) <u>LEON S. SHERR</u> M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3/21/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>1712 W. North Ave</u>			

Gilray Dr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3109</b>	
BIRTH NO.		70 3109		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>ELEANORA JACKSON</b>			2. DATE AND HOUR OF DEATH <b>3-3-70 6 pm M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1801</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Nursing &amp; Convalescent Center</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>2/18/1888</b>		9. AGE (In years lost birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>George Williams</b>			14. MOTHER'S MAIDEN NAME <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-14-8155</b>		17. INFORMANT
18. <b>4/12/31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/25/70</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerotic heart disease</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>		
			(C) <b>leg ulcers</b> <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 1970 to <b>3/3</b> 1970, that (I) (we) last saw the deceased alive on <b>3/3</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALAN H. MACHT M.D.</b>				23B. DATE SIGNED <b>3/3/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN H. MACHT M.D.</b>				23D. ADDRESS <b>2 E Reed St Balt, MD 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/9/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Howard St. W. Md.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <b>Robert E. Taylor, R.A.</b>	
24G. FUNERAL DIRECTOR <b>John J. Hall 1712 W. North A</b>		24H. ADDRESS		24I. DATE <b>MAR 24 1970</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WALKER CHAUNCEY D</b>		2. DATE AND HOUR OF DEATH <b>March 22 70</b>   <b>11:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND 38 HOSPITAL</b>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>22 S. GREENE ST. BALTIMORE, MARYLAND 21201</b>		C. CITY OR TOWN <b>BALTIMORE</b>
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>914 N. CAREY ST.</b>
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/00</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>CHARLES WALKER</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL CHART</b>	
18. <b>421.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>SUBENDOCARDIAL MYOCARDIAL INFARCT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>GENTAMYCIN TOXICITY</b> <b>SEPTICEMIA UNKNOWN ETIOLOGY</b> <b>BACTERIAL ENDOCARDITIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>20 hours</b> <b>10 days</b> <b>10 days</b> <b>20 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ARTERIOSCLEROSIS</b> <b>ARRHYTHMIC FIBRILLATIONS</b> <b>MITRAL INSUFFICIENCY</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>3. 3</b> 19 <b>70</b> to <b>3. 22</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3. 22</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DA [Signature]</b>			23B. DATE SIGNED <b>March 22 70</b>		23C. PHYSICIAN'S NAME (Type) <b>SAYED T.A. SHAH</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>BAILEY</b> <b>KEELSON B. H.</b>
			25D. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		25E. LOCATION <b>BALTO. Md.</b>
					25F. ADDRESS <b>1348 CALHOUN ST.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3111		70 3111	
BIRTH NO.				BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Barney, Benjamin</b>				2. DATE AND HOUR OF DEATH <b>3-19-70</b> <b>11:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b> <b>1514 Divison Street</b> <b>Baltimore, Maryland 21217</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>1602</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1013 WhatCoat St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-11</b>		9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>M. A. Active DSS</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Barney</b>				14. MOTHER'S MAIDEN NAME <b>Alethea Smith</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1544-2246</b>		17. INFORMANT <b>Isabell Barney-Wife</b>		ADDRESS <b>Same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <b>Probable Acute Myocardial Infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Arteriosclerotic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C)			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-19-70</b> 19 to <b>3-19-70</b> 19 that (I) (we) last saw the deceased alive on <b>3-19-70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Elijah Saunders</b>				23B. DATE SIGNED <b>March 20, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>ETIJAH SAUNDERS</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-24-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>V. BAILEY</b>		ADDRESS <b>KELSON F.W. 1348 CALHOUN ST.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3112				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3112			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>TRAWINSKI Agnes</b>				2. DATE AND HOUR OF DEATH <b>21 Mar 70 12<sup>00</sup> NOON</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>601</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Fayette Convalescent Home</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Balt</b>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>18 N. Linwood Ave 21224</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 8, 1906</b>		9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sales lady</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John Tramski</b>				14. MOTHER'S MAIDEN NAME <b>Julia Marzalek</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-05-1805</b>		17. INFORMANT <b>Joseph TRAWINSKI</b>				ADDRESS <b>18 N. Linwood Ave</b>	
18. <b>250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CHF (acute)</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CHF (acute)</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few hrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>None</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>None</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sev. Yrs</b>			
(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mell.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>" "</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>chr. Br. Synd.</b>											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>26 Feb 19 68</b> to <b>21 Mar 19 70</b> , that (I) (we) last saw the deceased alive on <b>21 Mar 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>J. Hulla MD</b>				23B. DATE SIGNED <b>21 Mar 70</b>							
23C. PHYSICIAN'S NAME (Type) <b>J. Hulla MD</b>				23D. ADDRESS <b>2214 E Fayette St Balt Md 21231</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-25-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery Baltimore Md.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber MD</b>		25C. FUNERAL DIRECTOR <b>BDABROWSKI</b>		25D. ADDRESS <b>2214 E. Fayette St Baltimore Md.</b>					

in

improvement

of the

the 1st of January 1881

for

3-25-70  
Blanchard & Co. Boston

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3113	REG. NO. 70 3113
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Armiger, Charles Francis</i>		2. DATE AND HOUR OF DEATH <i>3/20/70 5.25 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21206 2632</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>4801 Calumet Avenue</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-12-97</i>		9. AGE (In years last birthday) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Armiger, Conrad</i>			14. MOTHER'S MAIDEN NAME <i>Rose Lesser</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i>		16. SOCIAL SECURITY NO. <i>21440-1011</i>		17. INFORMANT <i>MARY ARMIGER 4801 CALUMET AVE.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial infarction</i>			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic heart disease</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <i>3-19 1970</i> to <i>3-20 1970</i> , that (I) ( <u>we</u> ) last saw the deceased alive on <i>3-20 1970</i> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <i>V. Chitraplee</i>				23B. DATE SIGNED <i>3-20-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>V. Chitraplee</i>				23D. ADDRESS <i>North Charles General Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIED</i>		24B. DATE <i>3/23/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem. Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1970</i>		25B. NAME OF REGISTRAR <i>Rose Lesser</i>		25C. FUNERAL DIRECTOR <i>B. DABROWSKI 2818 E Balto. St.</i>	





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3114				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3114			
1. NAME OF DECEASED (Type or Print) <b>JOHN G. WOLF (JOHN G. WOLF)</b>				2. DATE AND HOUR OF DEATH <b>3/23/70 9:42 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2611</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>623 South Clinton Street 21224</b>											
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-9-01</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Chauffeur</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Wolf</b>				14. MOTHER'S MAIDEN NAME <b>Anna B. Wolf</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>705-12-2783A</b>		17. INFORMANT ADDRESS <b>4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>450X</b> <b>CAUSE OF DEATH</b> <b>CHIEF OR ASST. MEDICAL EXAMINER</b> <b>M.D.</b> <b>OFFICER</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> <b>POSSIBLE PULMONARY EMBOLISM</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Slowing of UNDERLYING CONDITION lost.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC LUNG DISEASE</b> <b>ASCVD - SEVERE</b>				<b>24 hrs</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <del>(he)</del> <b>(this hospital)</b> attended the deceased from <b>3-23</b> 19 <b>70</b> to <b>3/23</b> 19 <b>70</b> , that <del>(he)</del> <b>(we)</b> last saw the deceased alive on <b>3/23</b> 19 <b>70</b> and that in <del>(my)</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> <b>(We)</b> (did) <del>(not)</del> view the body after death.											
23A. SIGNATURE <b>Richard M. Thaller M.D.</b>						23B. DATE SIGNED <b>3/23/70</b>					
23C. PHYSICIAN'S NAME (Type) <b>Richard M. Thaller M.D.</b>						23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland BALTIMORE CITY HOSPITAL 21224, MD.</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-26-70.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd., Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Charles S. Jailer</b>		25C. FUNERAL DIRECTOR ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-320 70 3115		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3115	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILBUR R. LEITCH</b>		2. DATE AND HOUR OF DEATH <b>3/22/70 5:25P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEM. HOSP. BALTO., MD.</b>		E. STREET AND NUMBER <b>3900 N. CHARLES</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/04/83</b>	9. AGE (in years last birthday) <b>86</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SELF EMP. FOOD PRODUCTS</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>MR. JOHN V. LEITCH</b>		14. MOTHER'S MAIDEN NAME <b>ELLA D. HOWARD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-0350</b>		17. INFORMANT <b>JOHN H. LEITCH</b> ADDRESS <b>BALTIMORE, MD.</b>	
18. <b>4/10/91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>COPONARY ART. DK M.I.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/19/70</b> to <b>3/22/70</b> that (I) (we) last saw the deceased alive on <b>3/22/70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harvey B. Sher MD.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/22/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARVEY B. SHER M.D.</b>		23D. ADDRESS <b>66 UNION MEM. HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>	24B. DATE <b>3/25/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Company</b> ADDRESS <b>4905 York Road, Balto., Md. 21212</b>	

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70 3116

BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. 70 3116 REG. NO. 70 3116

S-324

1. NAME OF DECEASED (Type or Print) <b>HUGHEY ST. CLAIR</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1539 Montpelier St.</u>		3. DATE PRONOUNCED DEAD Month <u>3</u> Day <u>22</u> Year <u>70</u> Hour <u>4:46 P.M.</u>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>907</u>			
6. SEX <u>Male</u>	7. RACE <u>Negro</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>9-10-29</u>		10. AGE (In years lost birthday) <u>40</u>		E. STREET AND NUMBER <u>1539 Montpelier St.</u>			
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Hughey St Clair</u>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Annie Chapman</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>241-32-3027</u>		18. INFORMANT <u>Mrs. Elnora St. Clair</u> ADDRESS <u>1539 Montpelier</u>			
19. <u>3-08-70</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Acute laryngeal edema</u> DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____					
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-23-70</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/26/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>		25B. NAME OF REGISTRAR <u>John J. Fisher</u>		25C. FUNERAL DIRECTOR <u>Wm C March</u>		ADDRESS <u>928 E. North Ave.</u>	

9-10-77

North Carolina

Charlotte

North Carolina

Charlotte

9-10-77

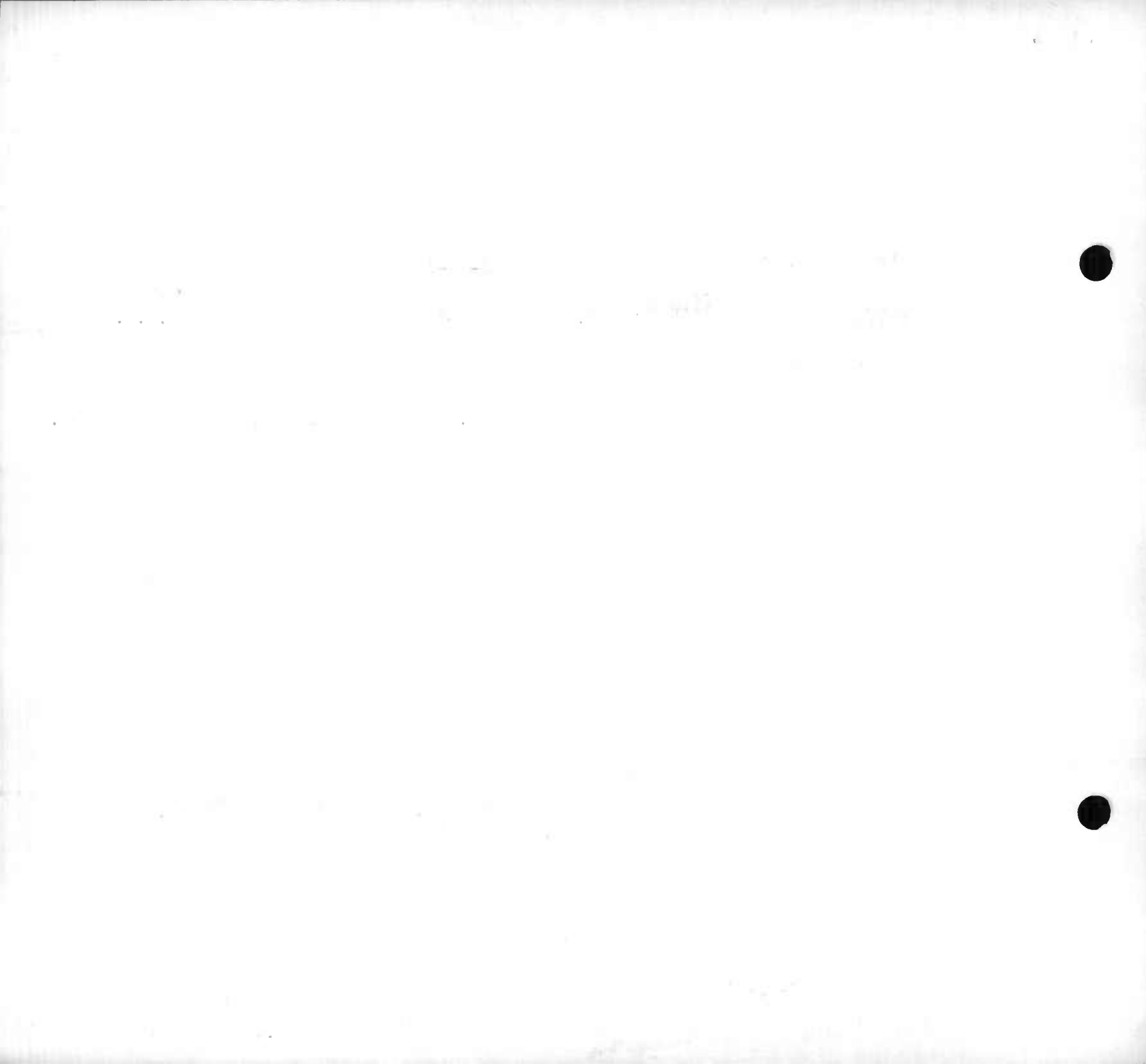
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3117</u>	
<u>S-350</u> <u>70 3117</u> BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SUTTON, MORRIS</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>		2. DATE AND HOUR OF DEATH <u>3-20-70</u> <u>1 3 A</u> M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CISA</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6132 Green Meadow PKWY #19</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1898</u>	9. AGE (In years last birthday) <u>72</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUTTER</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUTTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVID SUTTON</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. ADELE SUTTON, 6132 GREEN MEADOW PKWY.</u>			
18. <u>403X1</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last					
(A) IMMEDIATE CAUSE <u>Nephroclerosis, Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: <u>may years</u> (B) <u>Arteriosclerosis, Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 6,</u> 19 <u>70</u> to <u>MARCH 20,</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MARCH 20,</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Y. YORRO</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>YORRO</u>	
23D. ADDRESS <u>SINAI HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>3-22-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>		25B. NAME OF REGISTRAR <u>E. J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-416		70 3118		70 3118	
1. NAME OF DECEASED (Type or Print) <b>NATHAN HALPREN</b>			2. DATE AND HOUR OF DEATH <b>3/20/70 9 PM M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>B. COUNTY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAR HOSP. BALTO</b>			C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>3900 LAUSANNE RD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/24</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRORIETOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SILVER DOLLAR CAFE</b>		11. BIRTHPLACE (State, or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>ISRAEL HALPREN</b>		14. MOTHER'S MAIDEN NAME <b>CHIA ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. FANNIE HALPREN, 3900 LAUSANNE RD. #21133</b>	
18. <b>43691</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular accident</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Chronic renal disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic renal disease</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/14/70</b> 19 to <b>3/20/70</b> 19 that (I) (we) last saw the deceased alive on <b>3/20/70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. McVeny MD</b>				23B. DATE SIGNED <b>3/20/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>A MC VENY</b>				23D. ADDRESS <b>SI NAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-22-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>LIBERTY PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>			
25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

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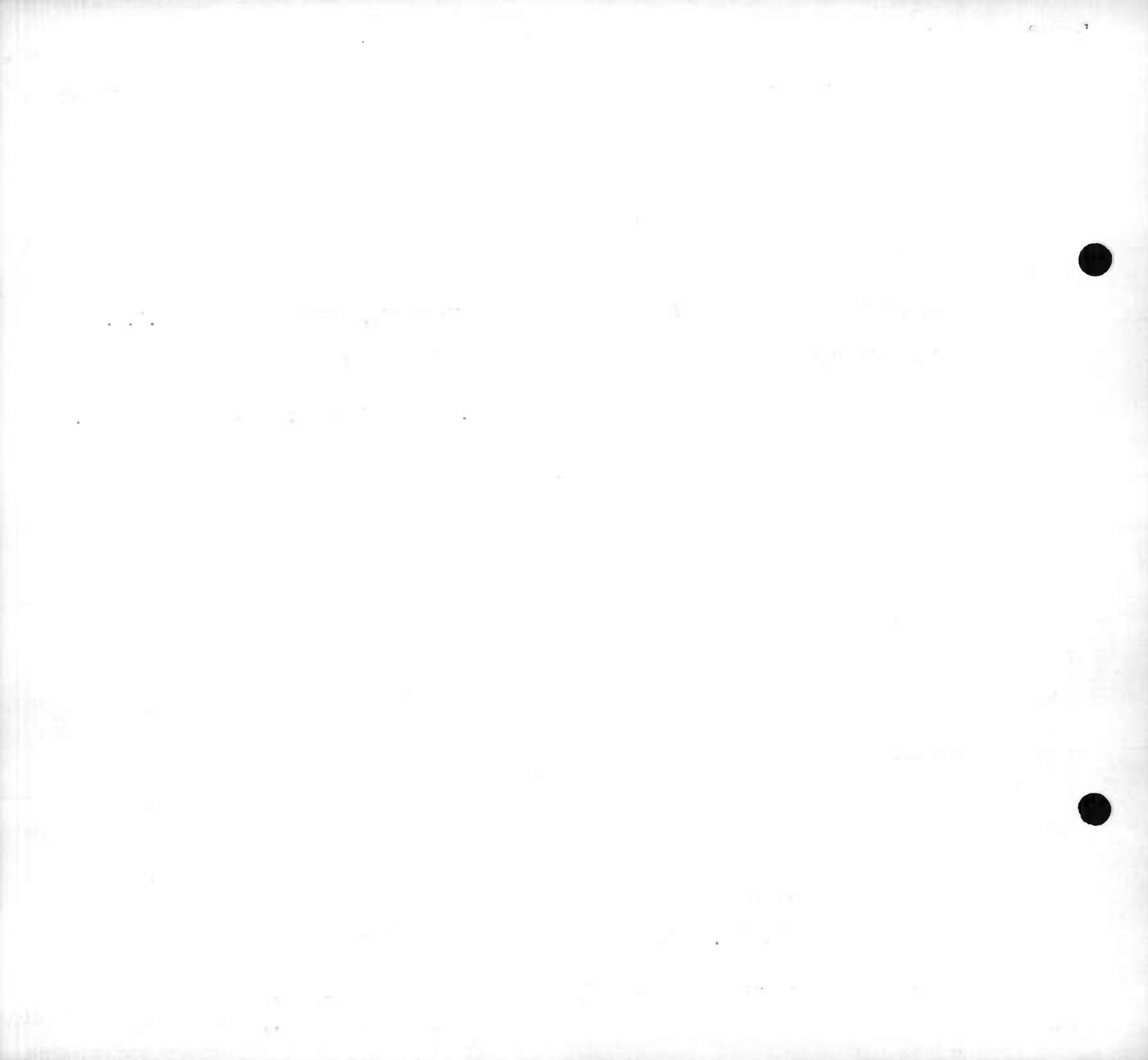
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3119</u>	
S-620 70 3119				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ruth Sirasky</u>				2. DATE AND HOUR OF DEATH <u>3/20/70 1930 A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> <u>42</u>				A. STATE <u>MD</u> B. COUNTY <u>1510</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>				E. STREET AND NUMBER <u>3401 GARRISON BLVD</u>	
6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/18</u>	
9. AGE (In years last birthday) <u>51</u>		10. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JACK SIRASKY</u>	
14. MOTHER'S MAIDEN NAME <u>FANNIE BERNSTEIN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. FANNIE SIRASKY, 3401 GARRISON BLVD. #15</u>		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Esophageal varices</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Chronic emphysema</u> (C) <u>Alcohol ingestion</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/20</u> 19 <u>70</u> to <u>3</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>3/20</u> 19 <u>70</u> and that (n) <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Ellis S Caplan MD</u>				23B. DATE SIGNED <u>3/20/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELLIS S. CAPLAN</u>				23D. ADDRESS <u>SINAI HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-22-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>AITZ CHAIM</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		24E. STATE <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>	
25B. NAME OF REGISTRAR <u>Robt. E. Jaber, MD.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		70 3120	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
BESSIE RICHMAN		3/21/70		12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
HOUSE IN THE PINES 90 BELVEDERE NURSING HOME		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		3809 CLARKS LANE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 10, 1902	67	11. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		WESTMINSTER, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HARRY ROSENSTOCK		LENA GOLIAN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MR. ABRAHAM RICHMAN, 3809 CLARKS LANE, APT. 108	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		7 days	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		approx 4 mos	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		approx 1 year	
		(C) OVARIAN CARCINOMA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
JAN 69		CA OVARY		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
0		0		0	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		0	
22. I certify that (X) (this hospital) attended the deceased from JAN 3 1965 to 3 21 1970 that (X) (we) last saw the deceased alive on 3 21 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
H. Gerald Oster MD		3/21/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
H. GERALD OSTER MD		6821 Reisterstown Rd BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3-23-70		HEBREW YOUNG MEN	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 24 1970		E. J. Taylor, M.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

1944-45

1945-46

1946-47

1947-48

1948-49

1949-50

1950-51

1951-52

1952-53

1953-54

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1955-56

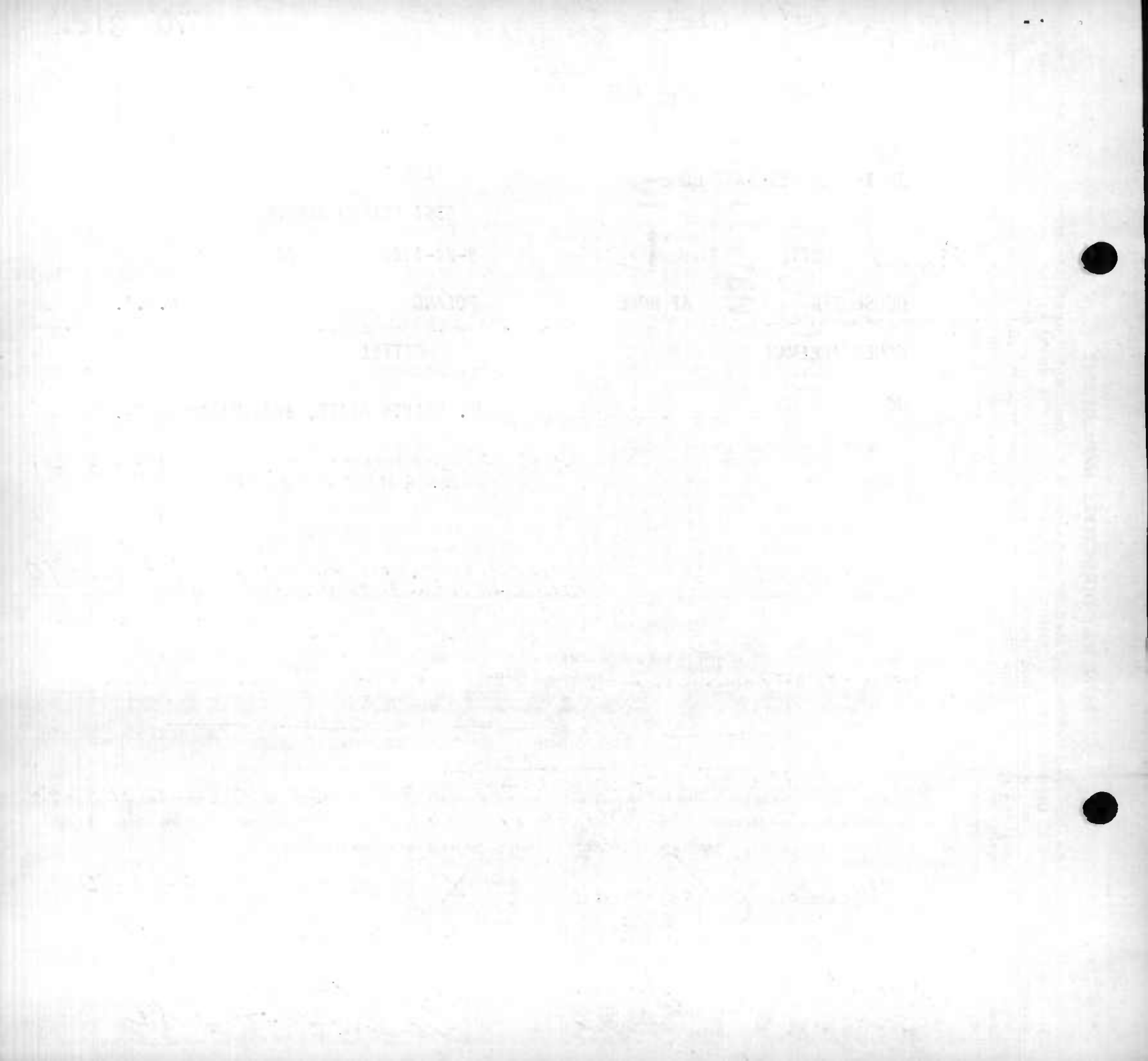
1956-57

1957-58

**FUNERAL DIRECTOR: IMPORTANT**

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Baltimore City Health Department				REG. NO. 70 3121	
B-430 70 3121					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Ida Blatt</i>			2. DATE AND HOUR OF DEATH <i>3/21/70 10:30 P. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>96 JEWISH CONVELESANT HOME</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2788</i>		
			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>5351 NELSON AVENUE</i>		
5. SEX <i>Female</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-20-1903</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>OSHER ADELMAN</i>			14. MOTHER'S MAIDEN NAME <i>GITTEL</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>MR. MELVIN BLATT, 6804 VATARUBA DR. #7</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Adenocarcinoma of sigmoid colon</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>2</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Carcinoma from sigmoid colon to liver and lungs</i> (C) <i>none</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-3-69</i> <i>3-22-70</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>April 24, 1969</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>adenocarcinoma sigmoid colon</i>		20A. AUTOPSY? (Yes or No) <i>none</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 3 1969</i> to <i>March 21 1970</i> , that (I) (we) last saw the deceased alive on <i>March 21 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Milton E. Lowman</i>				23B. DATE SIGNED <i>3-22-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>MILTON LOWMAN</i>				23D. ADDRESS <i>1401 Reisterstown Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/23/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Rudman Verein</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balt, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1970</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John E. Taylor, M.D.</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 3122</span>	
L-200 70 3122				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ALFRED LEWIS</span>				MARCH 22, 1970 2:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">37</span> MERCY HOSPITAL				A. STATE <span style="font-size: 1.2em;">MARYLAND</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <span style="font-size: 1.5em;">302</span>	
				C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">925 E. BALTIMORE STREET</span>	
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3-26-1910</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">59</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">PRINTER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">S. GOLDMAN &amp; CO.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">ABRAHAM LEWIS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">GOLDIE WEINBERG</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-09-8773</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">JUDGE HAROLD LEWIS, 4009 BOWERS AVE.</span>	
18. <span style="font-size: 1.5em;">277X 10</span> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				<span style="font-size: 1.5em;">Coronary Occlusion</span> <span style="font-size: 1.2em;">immediate</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<span style="font-size: 1.5em;">Nephritis</span> <span style="font-size: 1.2em;">Many years</span>	
(C) <span style="font-size: 1.5em;">Sedentary Obesity</span>				<span style="font-size: 1.2em;">Many Years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.5em;">Sedentary infected a gunner</span>				<span style="font-size: 1.2em;">years</span>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 18, 1970</span> to <span style="font-size: 1.2em;">March 22, 1970</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">March 22, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Harry Linden</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">Mar. 23, 1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HARRY LINDEN</span>				23D. ADDRESS <span style="font-size: 1.2em;">M.D. 14 S. BROADWAY</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">3-23-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 24 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. J. J. J.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>	

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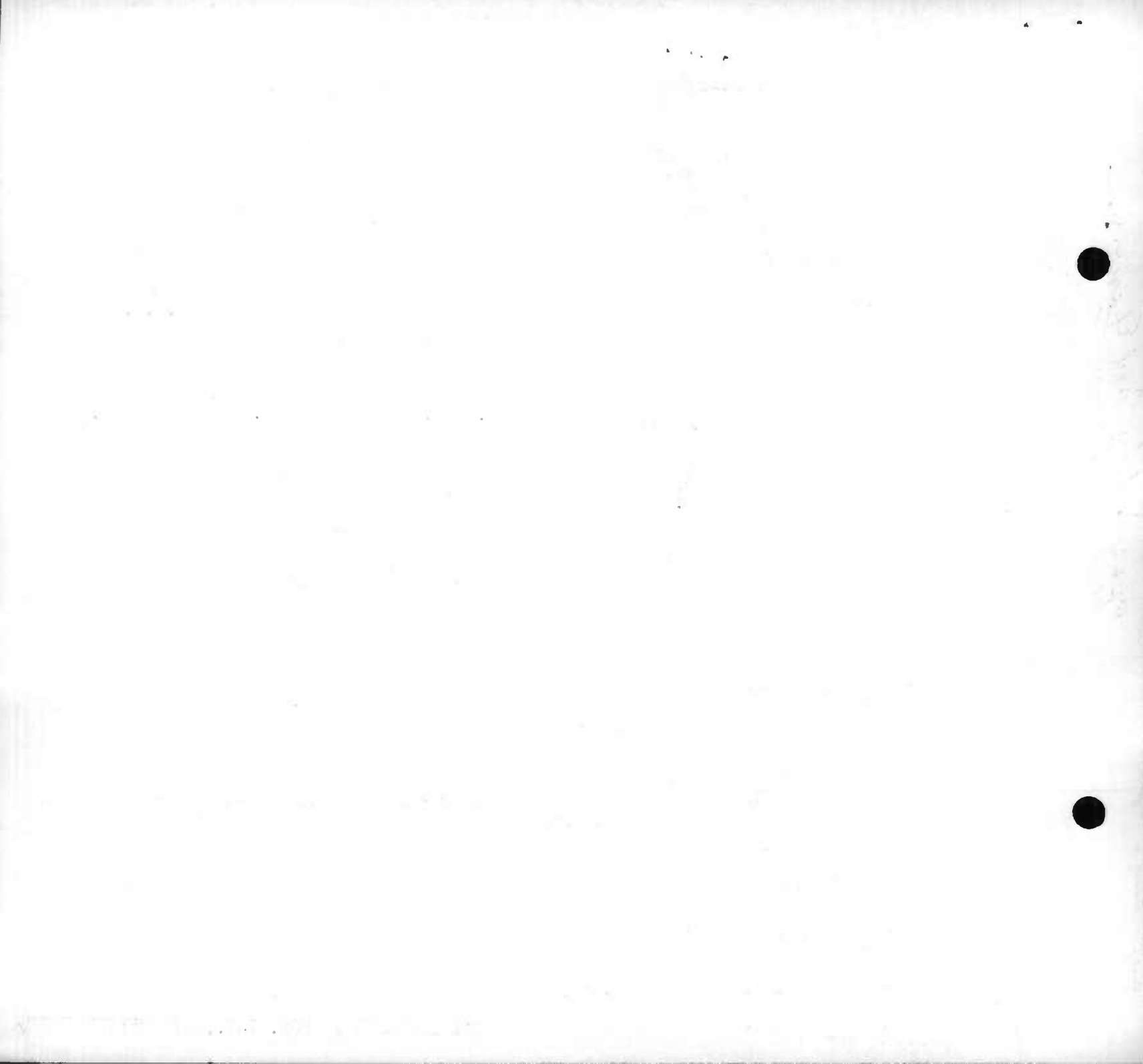
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Approved by Med Examiner  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-230 70 3123		CERTIFICATE OF DEATH		70 3123	
1. NAME OF DECEASED (Type or Print) MASSUDA, Rachel			2. DATE AND HOUR OF DEATH 3-21/70 - 6:25 PM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore 42			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND 2788		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3919 W. ROGERS AVENUE		
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3/98	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) EGYPT	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH ASLAN			14. MOTHER'S MAIDEN NAME REFCA ?		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT HEBREW FREE BURIAL SOCIETY, c/o Mr. MOSE MORRIS JR., 109 MARKET PL. #21202			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fractured Rt. Hip. Diabetes Mellitus.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION 2-25/70			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex. Rt. Hip -		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes -			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at Home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4009 Lanier Ave 27-17			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 2 21 70 - 8:30		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? fell out of chair		
22. I certify that (I) (this hospital) attended the deceased from 2-21-1970 to 3-21-1970 that (I) (we) last saw the deceased alive on 3-21-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Banderas M.D.			23B. DATE SIGNED 3-21/70 -		
23C. PHYSICIAN'S NAME (Type) JULIO BANDERAS M.D.			23D. ADDRESS Sinai Hospital of Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-23-70		24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970		25B. NAME OF REGISTRAR J. Banderas		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS. INC., 6010 REISTERSTOWN	
25D. ADDRESS BALTIMORE, MARYLAND					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-150		70 3124		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3124			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) PAUL B DEVON				2. DATE AND HOUR OF DEATH MARCH 20, 1970 2:15 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.				5. CITY OR TOWN BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male				6. RACE Cau.				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH OCT. 29, 1910			
MODEL MAKER Aberdeen Proving				PENNsylvania				9. AGE (in years last birthday) 59			
13. FATHER'S NAME GEORGE K DEVON				14. MOTHER'S MAIDEN NAME JESSIE BURCHARD				11. BIRTHPLACE (State or foreign country)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 173-07-5213				12. CITIZEN OF WHAT COUNTRY? U. S. A			
17. INFORMANT Mrs Mary Devon 531 Old Home Road 21206				ADDRESS							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE CA stomach with							
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DISTAL NODES							
(C)											
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/26/70 to Mar 20 1970				that (I) (we) last saw the deceased alive on March 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Julie P. Plavens MD				23B. DATE SIGNED 3/20/70							
23C. PHYSICIAN'S NAME (Type) JOSEPH TO S. ALMARIN MD				23D. ADDRESS U. M. H.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-23-70				24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			
24D. LOCATION (City, town, or county) (State) Parkville Balto. Md.											
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970				25B. NAME OF REGISTRAR Robert E. Talley, MD				25C. FUNERAL DIRECTOR Sarahn Funeral Home			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
B-320				70 3125		70 3125	
1. NAME OF DECEASED (Type or Print) <b>BEATRICE BATES</b>				2. DATE AND HOUR OF DEATH <b>3.18.70</b> <b>12-15P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>35 CHURCH HOME AND HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME AND HOSPITAL</b>				E. STREET AND NUMBER <b>9903 FALLS VIEW COURT</b> Perry Hall			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.22.19.</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>University of Md.</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>
13. FATHER'S NAME <b>John G. Chown.</b>				14. MOTHER'S MAIDEN NAME <b>Katherine L. Barnard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr Prabir K. Bose</b> ADDRESS <b>Church Home and Hospital</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>174 X1</b> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] <b>CEREBRAL METASTASES</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA BREAST.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3.17.1970</b> to <b>3.18.1970</b> that (I) (we) last saw the deceased alive on <b>3.18.1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Prabir K. Bose MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>PRABIR K. BOSE</b> H.D. DEGREE				23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-21-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Bailey, R.D.</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b> ADDRESS <b>7401 Belair Road 21236</b>	





# FUNERAL DIRECTOR: IMPORTANT

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G-140 70 3126		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3126	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>John C. Gavel, Sr.</b>				2. DATE AND HOUR OF DEATH <b>3/21/70 4:35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home &amp; Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital 35 Baltimore Maryland 21201</b>				C. CITY OR TOWN <b>Edgemere</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>2115 Lincoln Ave</b>		<b>21219.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/07</b>	9. AGE (in years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker, Inspector</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob J. Gavel</b>				14. MOTHER'S MAIDEN NAME <b>Christina Sweda.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 09-1142</b>		17. INFORMANT (Wife) <b>Mrs. Lena E. Gavel</b> ADDRESS <b>2115 Lincoln Avenue Balto. Md. 21219</b>			
18. <b>150 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the esophagus.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Tubular Necrosis</b> <b>Pneumonia.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 M.</b> <b>few days</b> <b>few days.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>3/21/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of esophagus.</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/2</b> 19 <b>70</b> to <b>3/21</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/21/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose MARTINEZ MD</b>				23D. ADDRESS <b>Medical Out Bldg 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-24, 1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3127</span>	
T-520 70 3127		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Bessie Thomas		March 21, 1970 <span style="float: right;">M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		Maryland		Baltimore	
10A. USUAL OCCUPATION (If kind of work done during most of working life, even if retired)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER		12. CITIZEN OF WHAT COUNTRY?	
		4414 Belvieu Avenue		USA	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-12-1883	86	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Benjamin Franklin Thomas		Kate A. Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-03-8436		Mrs. Wm. H. Evans - 4414 Belvieu Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 19 70</u> to <u>March 21 19 70</u> , that (I) (we) last saw the deceased alive on <u>March 20 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Thomas G. Abbott		3-21-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Thomas G. Abbott		4509 Liberty Heights Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	3-24-70	Druid Ridge Cemetery	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAR 26 1970	Robert E. Taylor, Jr.	Armacost Funeral Chapel-4600 Liberty Hts			

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1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Willard Marshall		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Month Day Year		A. STATE B. COUNTY	
31 City Hospitals		Baltimore		3 20 70		9:05 a. M.		Maryland 2747	
6. SEX male		7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
10. AGE (In years last birthday) 59		# Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		2912 Westfield Ave.			
New Jersey		U.S.A.		John Marshall					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Tool Room		Western Electric		Elizabeth Post					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		Ave.	
No		216-03-5712		Ruth Lee Marshall		2912 Westfield			
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3/24/70		Meadowridge Cemetery		Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 24 1970		Robert C. Altenburg		Robert C. Altenburg Funeral Home, Inc.		6009 Harford Rd. - Balto., Md.		21214	

100-443886-1000

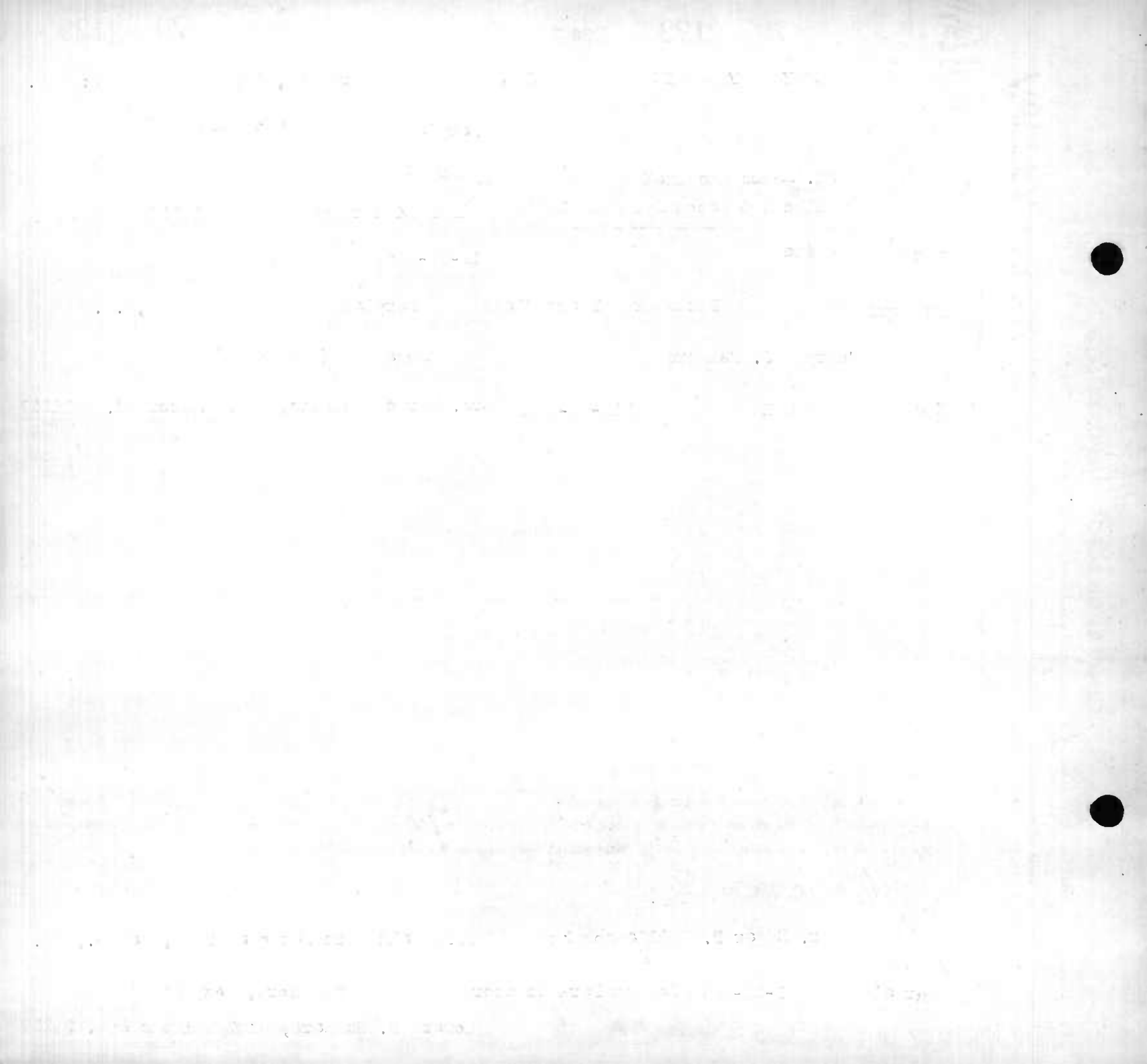
MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[Illegible text follows, including a signature and date]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-562 70 3129</b>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>70 3129</b>	
1. NAME OF DECEASED (Type or Print) <b>HENRY FREDERICK REIMERS</b>				2. DATE AND HOUR OF DEATH <b>March 20, 1970 7:00 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital Wilkins &amp; Caton Avenues 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5300</b> C. CITY OR TOWN <b>Arbutus</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1565 Lister Road 21227</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1894</b>		9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pittsburgh Plate Glass</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry J. Reimers</b>				14. MOTHER'S MAIDEN NAME <b>Anna ( Unknown )</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W I</b>		16. SOCIAL SECURITY NO. <b>213-05-3015</b>		17. INFORMANT ADDRESS <b>Mrs. Marie Reimers, 1565 Lister Rd. 21227</b>					
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Vascular Accident</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIO-SCLEROSIS</b> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 HRS</b> <b>YEARS</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>3/24/70</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1960</b> to <b>1970</b> present that (I) (we) last saw the deceased alive on <b>3/24</b> <b>1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Dr. Edgar P. Williamson 2nd</b> DEGREE _____				23B. DATE SIGNED <b>3/20/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Edgar P. Williamson 2nd</b> DEGREE _____			
23D. ADDRESS <b>5550 Baltimore National Pike, Balto., Md.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-23-1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>		25B. NAME OF REGISTRAR <b>Edgar E. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkins Ave. 21229</b>			



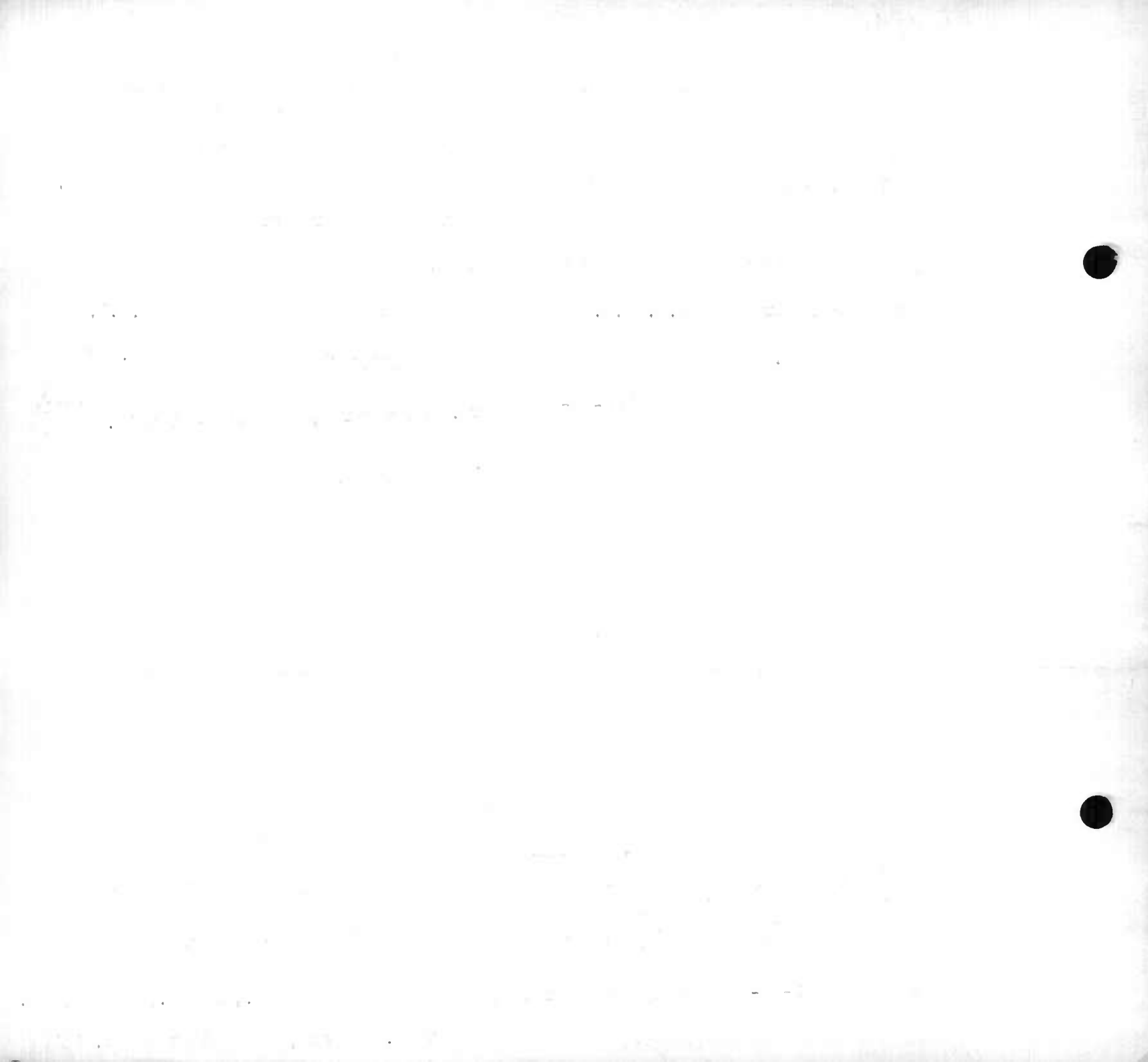




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

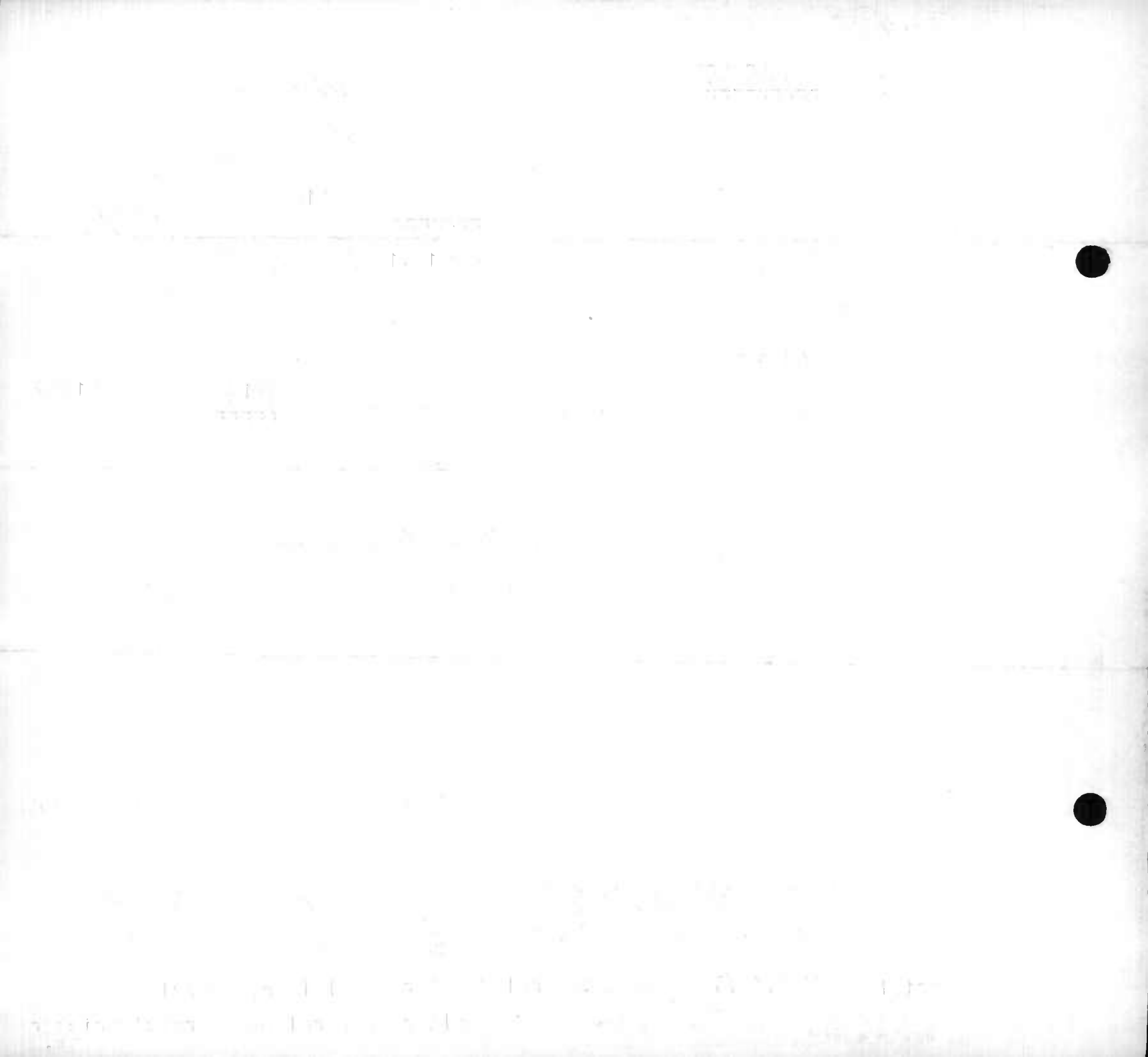
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 3130	
E-640 70 3130		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EARLE, John EDWARD		2. DATE AND HOUR OF DEATH 12:10 AM 3/19/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-31-98		9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT H. EARLE	
14. MOTHER'S MAIDEN NAME Anna B. Flinn		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-1783	
17. INFORMANT Mrs. Marie Earle, 813 Dorchester Rd.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATIONS 2/13/70, 3/13/70, 3/18/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC ANEURYSM - SUPPLEA THORACIC 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 3/1/70 to 3/19/70 that (I) (we) last saw the deceased alive on 3/19/70 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. 23A. SIGNATURE Arthur Jennings Jr. 23B. PHYSICIAN'S NAME (Type) ARTHUR JENNINGS JR. 23C. ADDRESS THE JOHNS HOPKINS HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3-23-70 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery 24D. LOCATION (City, town, or county) (State) Ritchie Hwy., Balto., County, Md. 25A. DATE REC'D BY HEALTH DEPT. MAR 24 1970 25B. NAME OF REGISTRAR E. J. J. J. 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

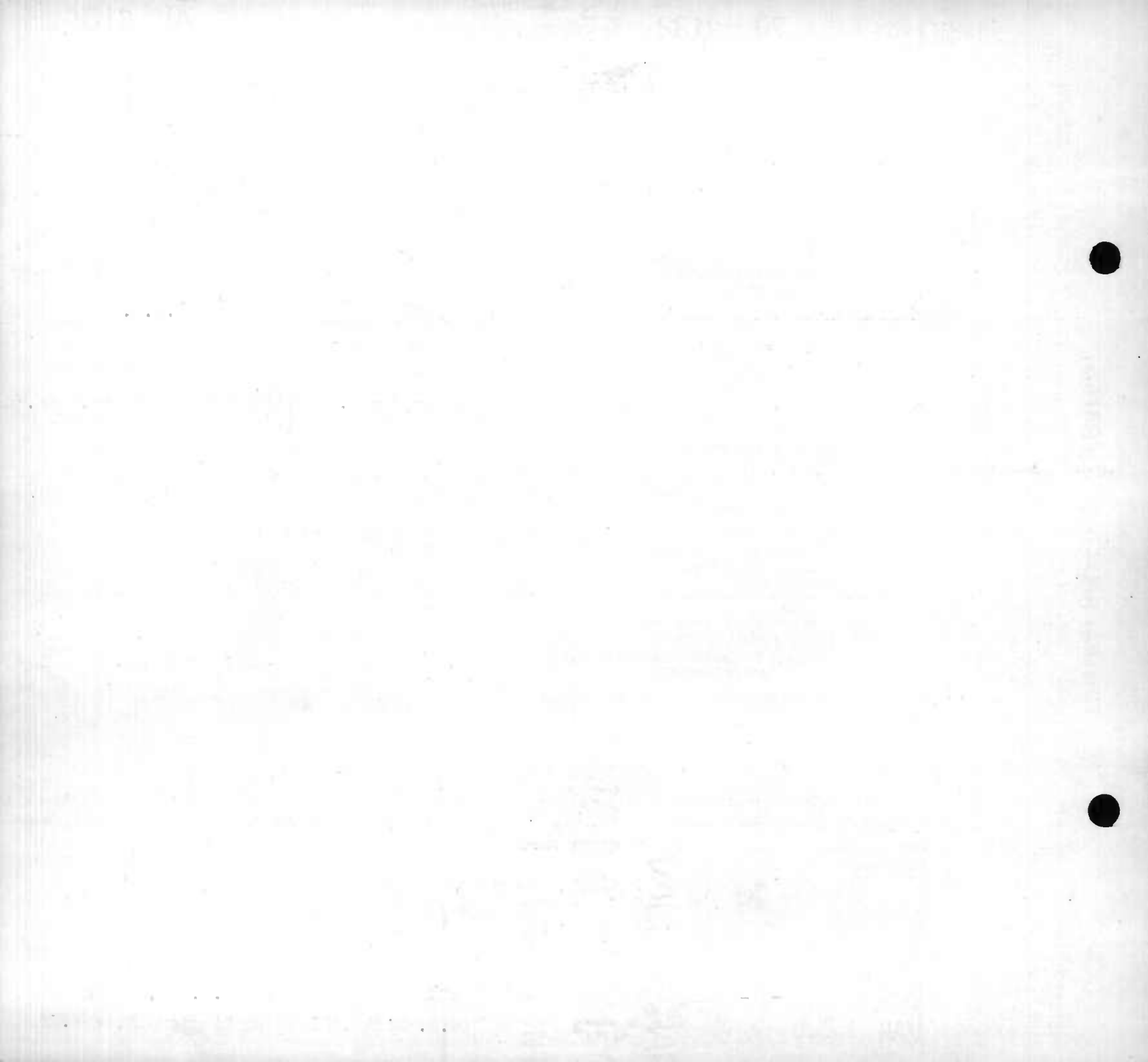
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>70 3131</u>	
BIRTH NO. <u>5-415</u>		70 3131		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>Barbara Schlepner</u>		2. DATE AND HOUR OF DEATH <u>March 21, 1970</u> <u>8<sup>10</sup> P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Barbar View Nursing Home</u>		A. STATE <u>Md</u>		B. COUNTY <u>Balto.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>901213 Light St</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>Apr 14, 1885</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Schatz (Guardian)</u>		9. AGE (In years last birthday) <u>84</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>24-26-1059</u>		17. INFORMANT <u>Mrs. Ann O'Neill</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic heart disease</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>yes</u>	
		(B) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>yes</u>	
		(C) <u>aneurysm</u>		<u>yes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>70</u> to <u>3/21</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/21</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALAN H. MAULT MD</u>				23B. DATE SIGNED <u>3/22/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MAULT MD</u>		23D. ADDRESS <u>2 E Red Red St Baltimore 2102</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/25/70</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1970</u>		25B. NAME OF REGISTRAR <u>John E. Walters</u>		25C. FUNERAL DIRECTOR <u>Walters Funeral Home Pratt &amp; Stricker</u>	
				ADDRESS <u>Pratt &amp; Stricker Sts.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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D-000 70 3132		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3132	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Roland Isaac Day</b>		2. DATE AND HOUR OF DEATH <b>6 AM 3/18/1970</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundle</b>		5. CITY OR TOWN <b>Annapolis</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>906 Carrollton Avenue</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/13</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marina Owner</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Clarence Day</b>		14. MOTHER'S MAIDEN NAME <b>Lena Butler</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unkn</b>		17. INFORMANT <b>Mrs Dorothy E. Day</b>	
18. <b>161.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Cardioresp. arrest secondary to prob. acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>initial Cardioresp. arrest one hour following hypopharyngoscopy</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Carcinoma of larynx</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>3/17/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>To remove tumor</b>	
20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>To determine cause of death</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that <b>Dr</b> (this hospital) attended the deceased from <b>3/17</b> 19 <b>70</b> to <b>3/18</b> 19 <b>70</b> , that <b>Dr</b> (we) last saw the deceased alive on <b>3/18</b> 19 <b>70</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>Dr</b> (We) (did) <b>not</b> view the body after death.	
23A. SIGNATURE <b>Loren George Lipson MD</b>		23B. DATE SIGNED <b>3/18/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Loren George Lipson, MD</b>	
23D. ADDRESS <b>Johns Hopkins Baltimore, MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-21-1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Pine Lawn Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis A.A. Co., Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 24 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Vickers</b>		25C. FUNERAL DIRECTOR <b>C.E. Hicks</b>		ADDRESS <b>111 30 Washington St, Anna. Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

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<p><b>P-100</b>      <b>70</b>      <b>3133</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70</b>      <b>3133</b></p>	
<p><b>BIRTH NO.</b> <b>70-04823</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>MARCH 21 1970</b>      <b>2:48AM</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>POPE BABY GIRL "A"</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MARYLAND</b>      <b>B. COUNTY</b> <b>2553</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUE BALTIMORE MARYLAND 21229</b></p>		<p><b>C. CITY OR TOWN</b> <b>BALTIMORE</b>      <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <b>2519 WASHINGTON BLVD 21230</b></p>	
<p><b>5. SEX</b> <b>FEMALE</b></p>	<p><b>6. RACE</b> <b>WHITE</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>03/20/70</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>12</b> <b>47</b> If Under 1 Yr. Months: Days:      If Under 24 Hrs. Min.</p>
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b></p>	
<p><b>13. FATHER'S NAME</b> <b>JOHN POPE</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>DOROTHY GURTLE</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	<p><b>17. INFORMANT ADDRESS</b> <b>ST AGNES HOSPITAL BALTIMORE MD 21229</b></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>769.4 I</b></p> <p><b>CAUSE OF DEATH</b></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>(A) IMMEDIATE CAUSE</b> <b>HYALINE MEMBRANE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>DISEASE</b></p> <p><b>(B) PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(C)</b></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>			
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>2</b></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (X) (this hospital) attended the deceased from <u>03/20/70</u> 19 to <u>03/21/70</u> 19 that (X) (we) last saw the deceased alive on <u>03/21/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>J. E. Garcia</i></p>		<p><b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/></p>	<p><b>23B. DATE SIGNED</b> <b>3-21-70</b></p>
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>JORGE E. GARCIA</b></p>		<p><b>23D. ADDRESS</b> <b>ST AGNES HOSPITAL BALTIMORE MD 21229</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>	<p><b>24B. DATE</b> <b>3/23/70</b></p>	<p><b>24C. NAME of CEMETERY or CREMATORY</b> <b>Meadowridge</b></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Elkridge Howard Md.</b></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 24 1970</b></p>	<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, Jr.</b></p>	<p><b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>J. I. Stansbury, Sr. 6411 Windsor Mill Rd.</b></p>	

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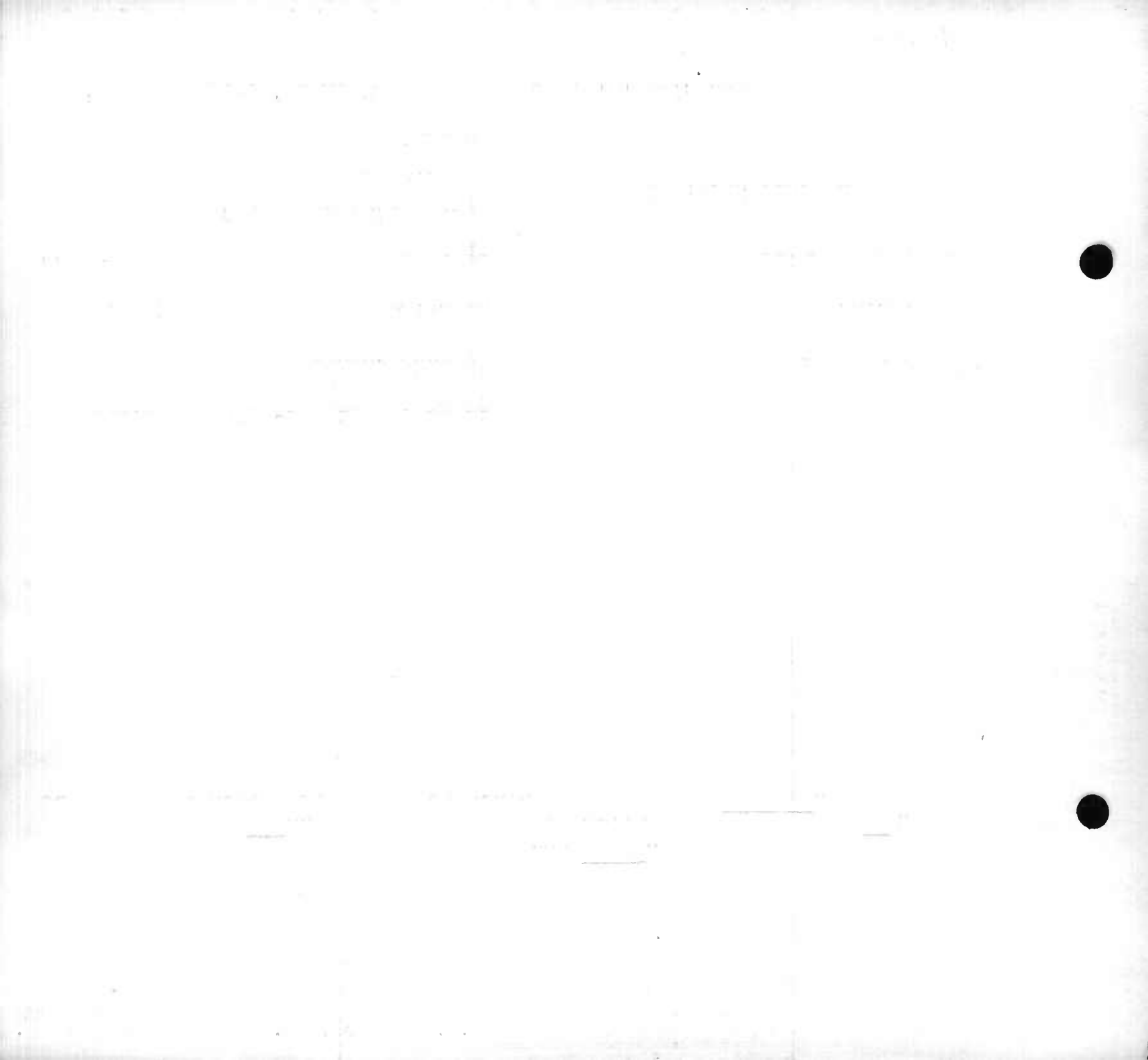
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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3134</span>	
<div style="font-size: 1.5em; float: left;">P-100</div> <div style="float: right;">70 3134</div>		<div style="font-size: 1.5em; float: left;">70-04824</div> <div style="float: right;">3134</div>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
BABY GIRL "B" POPE		MARCH 20, 1970 8:00 P.M.			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		6. RACE	
A. STATE MARYLAND		B. COUNTY BALTIMORE		WHITE	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2519 WASHINGTON BLVD				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 03 20 70		9. AGE (In years last birthday) 5 44		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JOHN POPE	
14. MOTHER'S MAIDEN NAME DOROTHY GURTLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ST AGNES RECORDS-BALTO MD 21229		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<div style="border: 1px solid black; padding: 5px;"> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div>	
<div style="border: 1px solid black; padding: 5px;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASPHIXIA NEONATORUM</u></p> </div>		<div style="border: 1px solid black; padding: 5px;"> <p>(B) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF:</p> </div>		<div style="border: 1px solid black; padding: 5px;"> <p>(C)</p> </div>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MARCH 20 19 70 to MARCH 20 19 70 that (X) (we) last saw the deceased alive on MARCH 20 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<i>Jorge E Garcia</i>		3-21-70		JORGE E GARCIA	
23D. ADDRESS		23E. DATE SIGNED		23F. PHYSICIAN'S NAME (Type)	
ST AGNES HOSP		3-21-70		JORGE E GARCIA	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/23/70		Meadowridge	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Elkridge Howard Md.		MAR 24 1970		J. T. Stansbury, Sr.	
24G. FUNERAL DIRECTOR		24H. NAME OF REGISTRAR		24I. DATE REC'D BY HEALTH DEPT.	
J. T. Stansbury, Sr.		J. T. Stansbury, Sr.		MAR 24 1970	
24J. ADDRESS		24K. NAME OF REGISTRAR		24L. DATE REC'D BY HEALTH DEPT.	
6411 Windsor Mill Rd.		J. T. Stansbury, Sr.		MAR 24 1970	



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C-600 70 3135 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3135

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MOSE CORRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 819 Pennsylvania Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour March 21, 1970 5:30 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/15/1911		10. AGE (In years, lost birthday) 59	
11. BIRTHPLACE (State or foreign country) SINERBY N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY	
15. FATHER'S NAME ADOLPHUS CORRY		15. MOTHER'S MAIDEN NAME VINNIE HAYES	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 243-01-6764	
18. INFORMANT MALLIE MONTGOMERY		ADDRESS 701 N. E. ...	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		3/22/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/26/70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		25B. NAME OF REGISTRAR J. ...	
25C. FUNERAL DIRECTOR Branch ...		ADDRESS ...	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>B-600</b>		70 3136		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>70 3136</b>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>AMELIA A. BOYER</b>				3/18/1970 2:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MD</b>		B. COUNTY <b>1601</b>	
528 N. ARLINGTON AVE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>528 N. ARLINGTON AVE</b>							
5. SEX <b>Fe</b>	6. RACE <b>Cul</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>10-19-1861</b>	9. AGE (In years last birthday) <b>109</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY PALMER</b>				14. MOTHER'S MAIDEN NAME <b>LAURA CHANDLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ELIZABETH SCOTT 528 N. ARLINGTON AVE</b>		ADDRESS	
18. <b>486X I</b>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Pneumonia</b>				<b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO					
		(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Antisclerotic</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>0</b>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>2-9-67</b> 19 to <b>3-18</b> 1970, that (I) (we) last saw the deceased alive on <b>3-18</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harland Churchill</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-20-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. Garland Churchill</b> M.D.				23D. ADDRESS <b>1038 Edmondson Ave</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burn</b>		24B. DATE <b>3/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Trinity Ave</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>James J. ...</b>		25C. FUNERAL DIRECTOR <b>James J. ...</b>		ADDRESS <b>638 N. ...</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3137

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NOAH RAYNER

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 21, 1970

1:00 A

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2533

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

3-21-70

10. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2333 Annapolis Road

11. BIRTHPLACE (State or foreign country)

Selma N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Rayner

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Eastern Products

15. MOTHER'S MAIDEN NAME

Nora

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes 5-29-53-6-11-56

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Elizabeth Rayner

ADDRESS

2410 Loyola N.

19.

E788X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Multiple traumatic injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Track

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

South Branch B&amp;O R.R. Track-

93' W. of 2000 Annapolis Road

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

3-21-70 1:00 A.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject struck by train

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/21/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/21/70

24C. NAME of CEMETERY or CREMATORY

Selma N.C.

24D. LOCATION (City, town, or county)

Selma N.C.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 25 1970

25B. NAME OF REGISTRAR

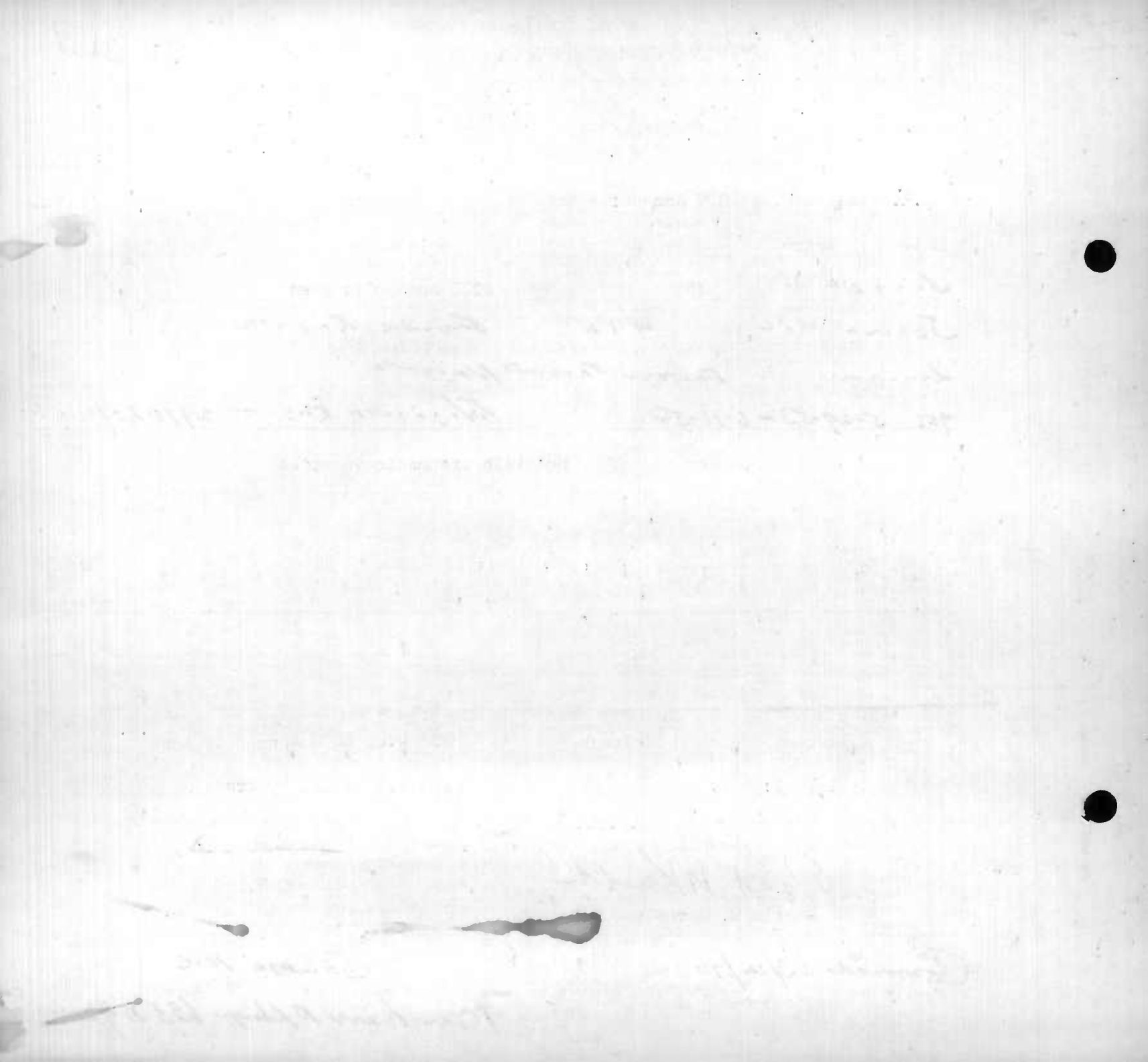
John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Marshall P. Hargis

ADDRESS

638 N. 9th St.





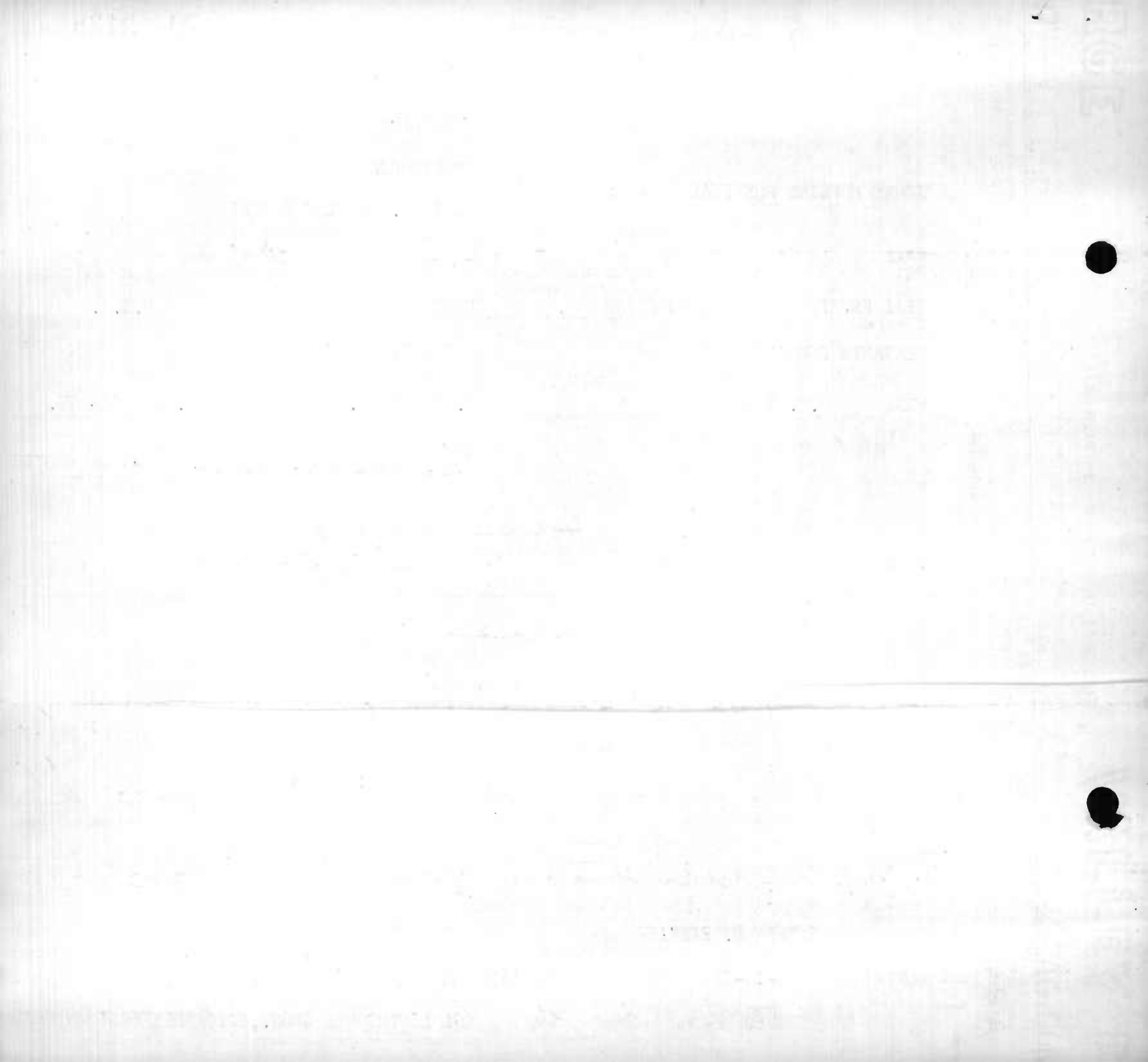
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

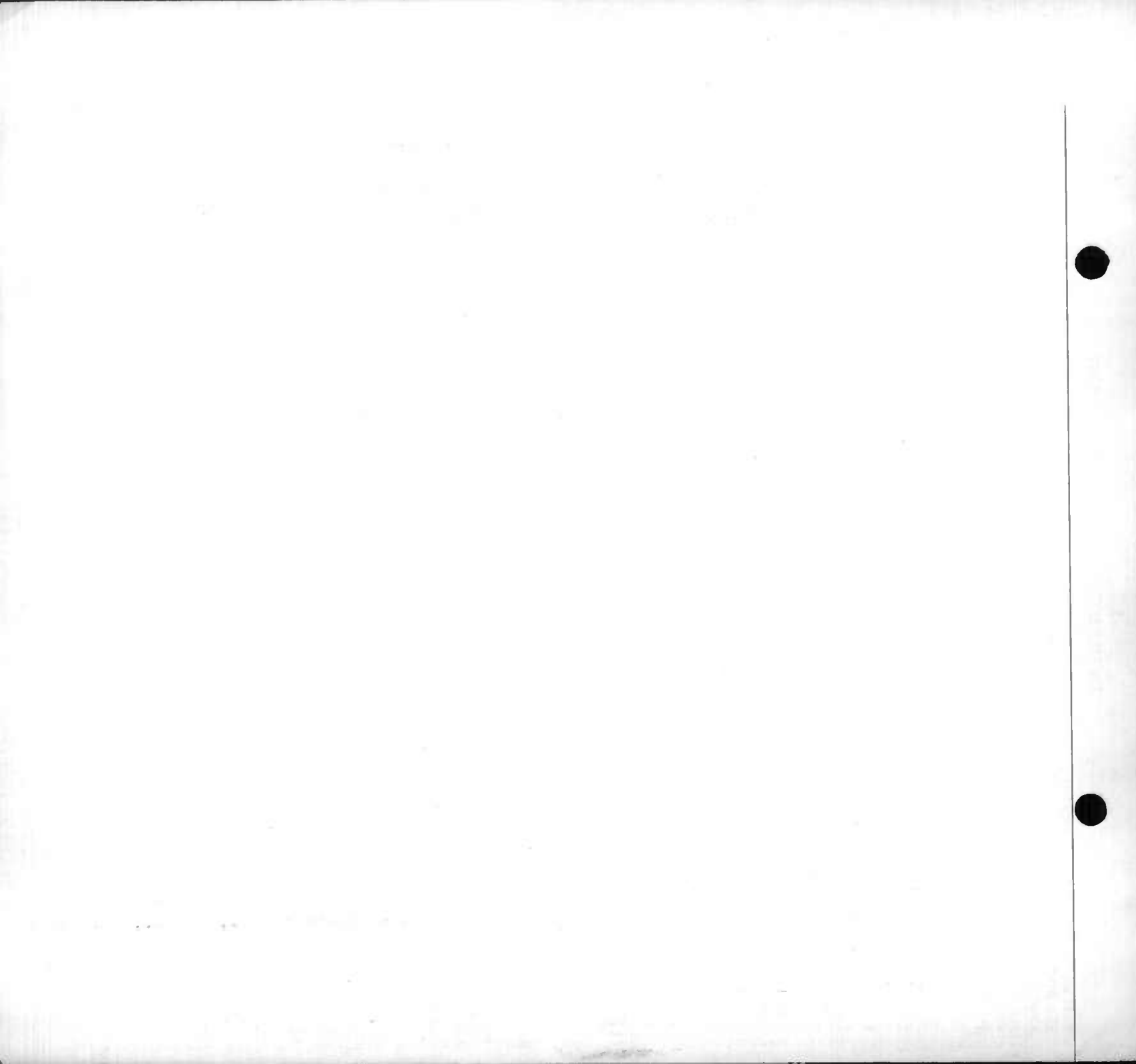
REG. NO. 70 3138

BIRTH NO. 70 3138		2. DATE AND HOUR OF DEATH MARCH 22, 1970 10 a.m.	
1. NAME OF DECEASED (Type or Print) ISRAEL DORMAN		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1201	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3915 N. CHARLES STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1893
9. AGE (In years last birthday) 76		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE		10B. KIND OF BUSINESS OR INDUSTRY INVESTOR	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN DORMAN		14. MOTHER'S MAIDEN NAME GOLDIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. CARRIE N. DORMAN, 3915 N. CHARLES ST. #18		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 401X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate (A) IMMEDIATE CAUSE Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension + 1968 attack of Pulmonary Embolism. (C)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, factory, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-14-64 19 to 3-19-70 19 that (I) (we) last saw the deceased alive on 3-19-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph N. Zierler M.D.		23B. DATE SIGNED 3-22-70	
23C. PHYSICIAN'S NAME (Type) JOSEPH N. ZIERLER		23D. ADDRESS 2502 N EUTAW PLACE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-70	
24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH (AITZ CHAIM)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT MAR 25 1970		25B. NAME OF REGISTRAR Isabel E. Taylor, R.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-324 70 3139		CERTIFICATE OF DEATH		70 3139	
1. NAME OF DECEASED (Type or Print) John Mitchell			2. DATE AND HOUR OF DEATH 3-15-70 10:50P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 842 West Pratt Street XXXXXX XXXX XXXX 21230		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-93	9. AGE (in years last birthday) 77	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME January		
14. MOTHER'S MAIDEN NAME Louise			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 220-01-5496			17. INFORMANT 4940 Eastern Avenue BCH Records-Baltimore, Maryland 21224		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 441.1 RUPTURED AORTIC ANEURYSM (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH R.A. ?
19A. DATE OF OPERATION 3/15/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ANEURYSM		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 3/15 1970 to 3/15 1970 that (I) (we) last saw the deceased alive on 3/15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. O. Fisher M.D.			23B. DATE SIGNED 3/15/70		23C. PHYSICIAN'S NAME (Type) STEVEN J. FRIEDMAN M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-21-70		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn
24D. LOCATION Baltimore City			24E. NAME OF DECEASED John Mitchell		24F. FUNERAL DIRECTOR Isaiah L. Brown & Son
24G. DATE REC'D BY HEALTH DEPT. MAR 25 1970			24H. NAME OF REGISTRAR John C. Fisher		24I. ADDRESS 100 W. Montgomery Street



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

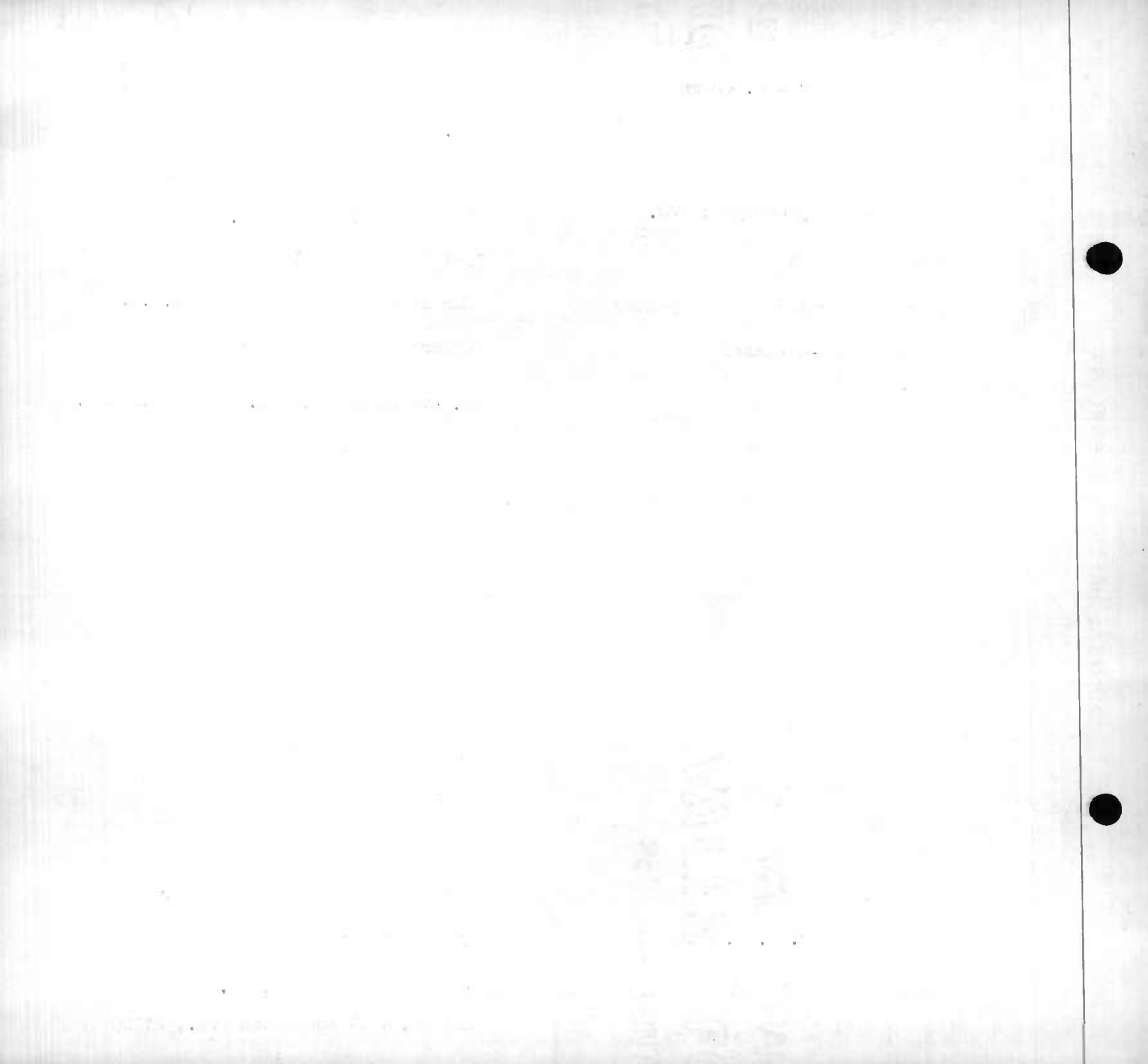
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3140</span>	
F-462 70 3140				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">70 3140</span>					
1. NAME OF DECEASED (Type or Print) <b>MANUEL T. FLORES</b>		2. DATE AND HOUR OF DEATH <b>3/23/70 10:30 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2844</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>818 WICKLOW ROAD.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/04</b>	9. AGE (in years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SEAMAN</b>		11. BIRTHPLACE (State or foreign country) <b>PHILIPPINES</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>ROSENDO FLORES</b>		14. MOTHER'S MAIDEN NAME <b>FAUSTINA TOROBA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>115-07-2478</b>		17. INFORMANT ADDRESS Mrs. Manuel T. Flores, 818 Wicklow Road <b>WIFE SAME</b>	
18. <b>15-7-71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARCINOMA TOSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Ca of PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> 19 <b>70</b> to <b>3/23</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Andrew M. Dale</b>		23B. DATE SIGNED <b>3/23/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Andrew M. Dale</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/26/70</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>R. E. J. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Avenue. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="font-size: 1.5em;">70 3141</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">J-520</span>		<b>70 3141</b>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Andrew D. Jones</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/23/70 11.55P M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">00 1 South Beechfield Ave.</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2864</span> <b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1 South Beechfield Ave.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11/13/1898</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">71</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Carpenter</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Carpenter</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Henry Jones-deceased</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Barbara deceased</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Mrs. Evelyn Jones, 1 S. Beechfield Ave. Apt B</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">492X1 Coronary Occlusion</span>			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Emphysema &amp; Pulmonary Fibrosis &amp; CVD</span>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">June 19 69</span> <b>to</b> <span style="font-size: 1.2em;">8/23 19 70</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">3/23 19 70</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">E. W. Johnson M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/24/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. E. W. Johnson</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">3432 Frederick Road</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/26/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 25 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Witzke, 4101 Edmondson Ave., 21229</span>			

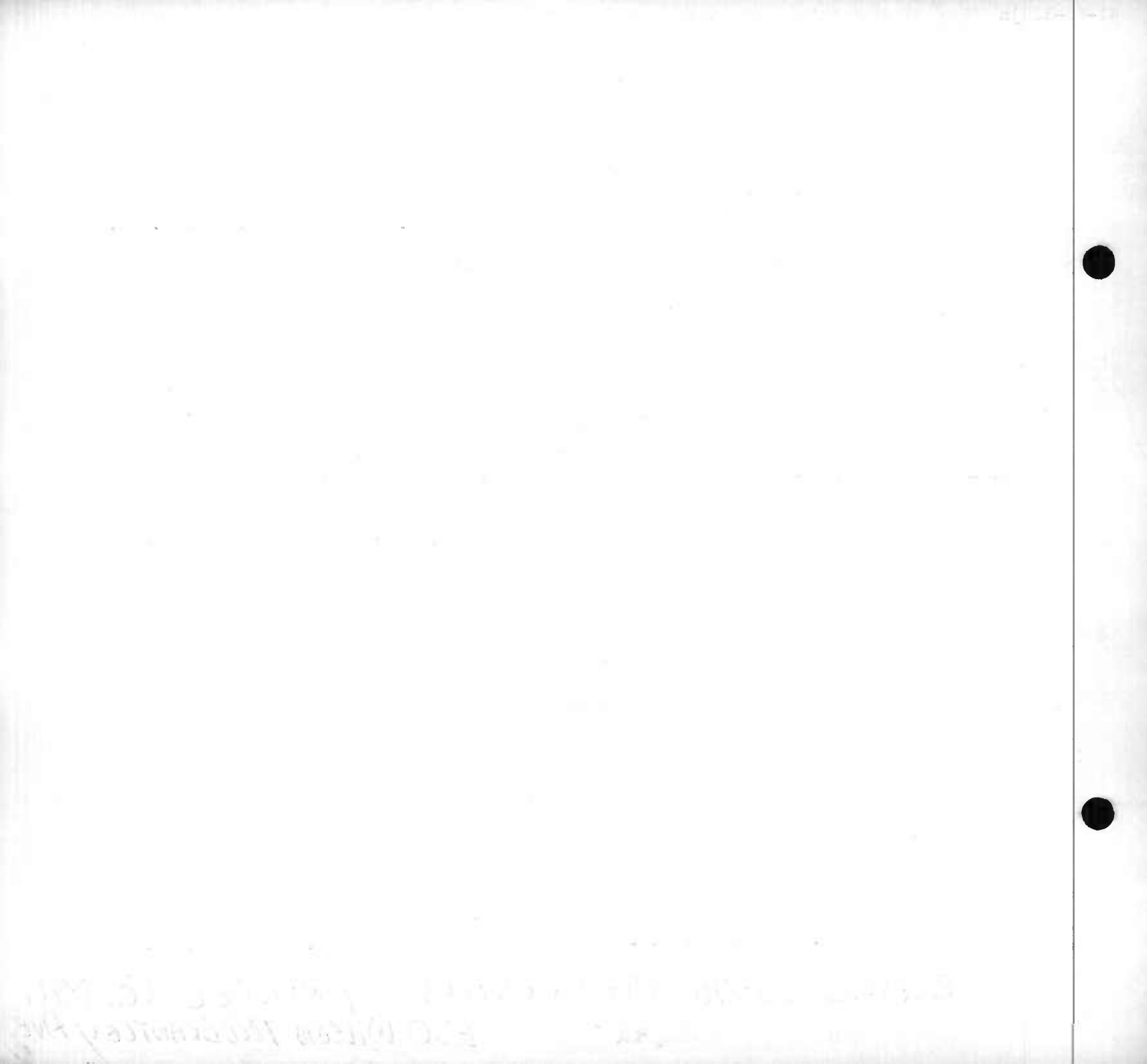




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

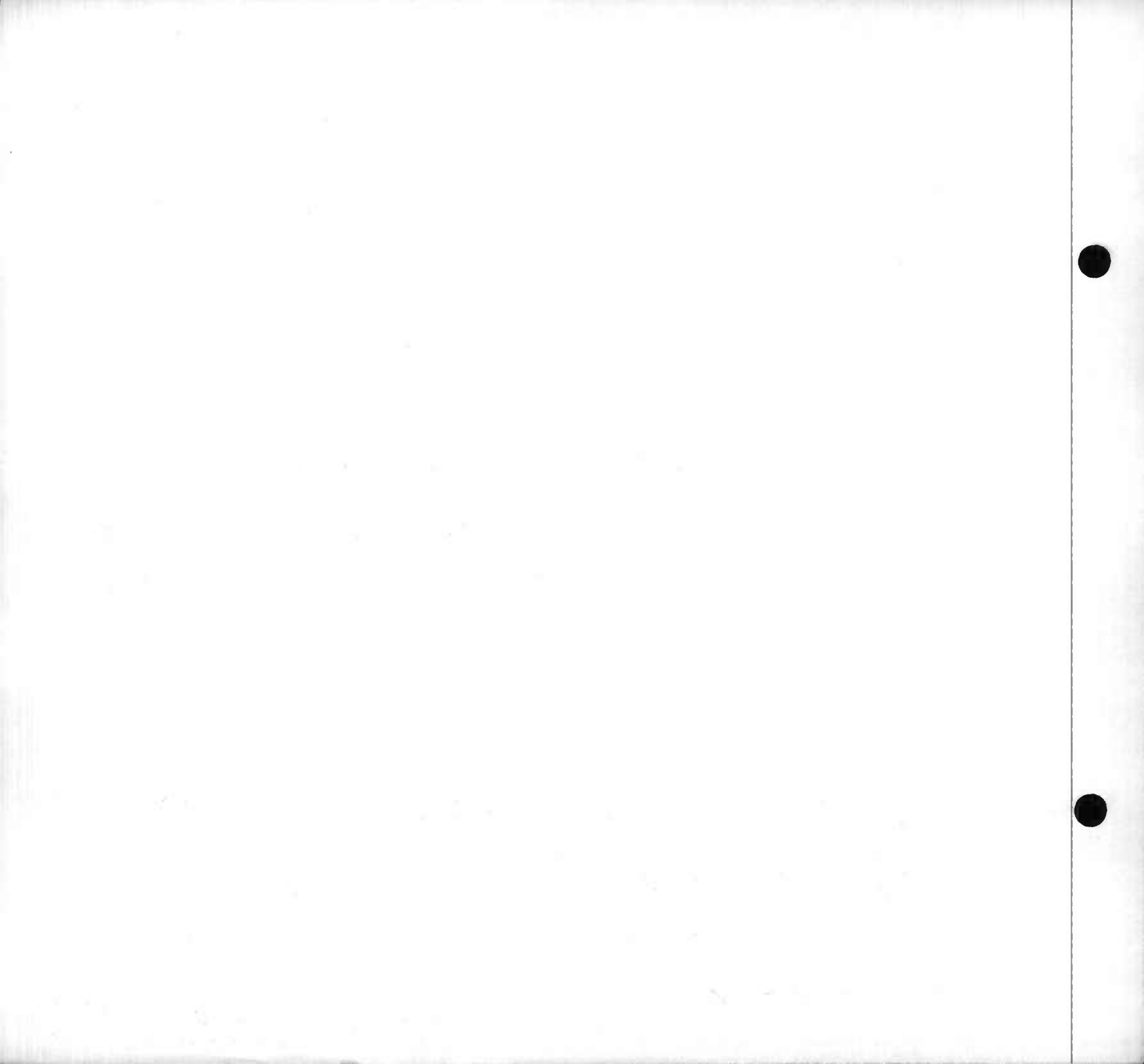
41-65-32		D-620 70 3142		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3142	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROGER BROOKS</b>				2. DATE AND HOUR OF DEATH <b>MARCH 18, 1970 10:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>604</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>1817 E. Fairmount Ave., Balto. Md. 21231</b>					
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-1886</b>		9. AGE (In years last birthday) <b>83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
13. FATHER'S NAME <b>John</b>				14. MOTHER'S MAIDEN NAME <b>Mary</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>27-05-425</b>		17. INFORMANT <b>4940 Eastern Avenue</b> BCH Records: Baltimore, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1571941 25017</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL Metastases</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? 1 month</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (B) <b>Carcinoma Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 yr</b>				(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes, ASVD</b>								<b>4 yr, many</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>March 16</b> 19 <b>70</b> to <b>March 18</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>March 18</b> 19 <b>70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dale N. Schumacher M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-18-70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dale N. Schumacher, M.D.</b>				23D. ADDRESS <b>Baltimore City Hospital 4940 Eastern Ave., Baltimore, Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-23-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>ARUNDEL Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>James E. Fisher, MD</b>		25C. FUNERAL DIRECTOR <b>H. O. Wilson</b>		ADDRESS <b>1000 BRANTLEY AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

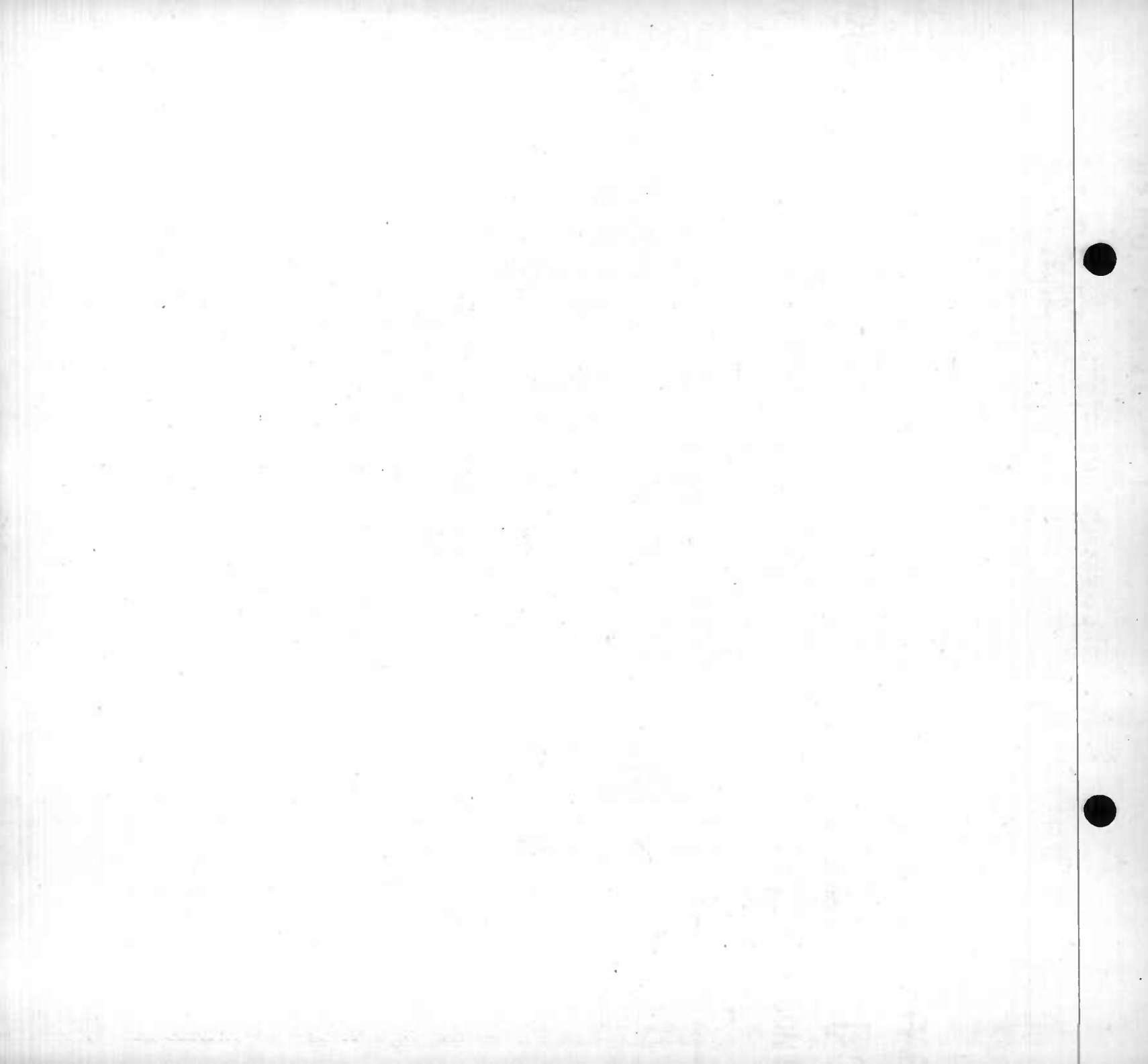
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
F-626 70 3143				70 3143	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>HARRY L FRAZIER</b>			2. DATE AND HOUR OF DEATH <b>3/23/70 12:40 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. MD. BALT., MD.</b>			C. CITY OR TOWN <b>BALT</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1802 E. MADISON ST</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/29</b>	9. AGE (In years last birthday) <b>40</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>—</b>			14. MOTHER'S MAIDEN NAME <b>—</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Patient</b>		ADDRESS
18. <b>30371</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO-PULM ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAY</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>PANCREATITIS</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>6 days</b>
			(C) <b>ALCOHOLISM</b>		<b>YEARS</b>
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>3/19/70</b> 19 <b>70</b> to <b>3/23</b> 19 <b>70</b> that <del>the</del> (we) lost saw the deceased alive on <b>3/23</b> 19 <b>70</b> and that <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Howard Wallach, MD</b>				23B. DATE SIGNED <b>3/23</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>HOWARD WALLACH, MD</b>		<b>UNIV. MD BALT</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>3-25-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>MT. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Elmer C. Wilson</b>	
				ADDRESS <b>2191</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

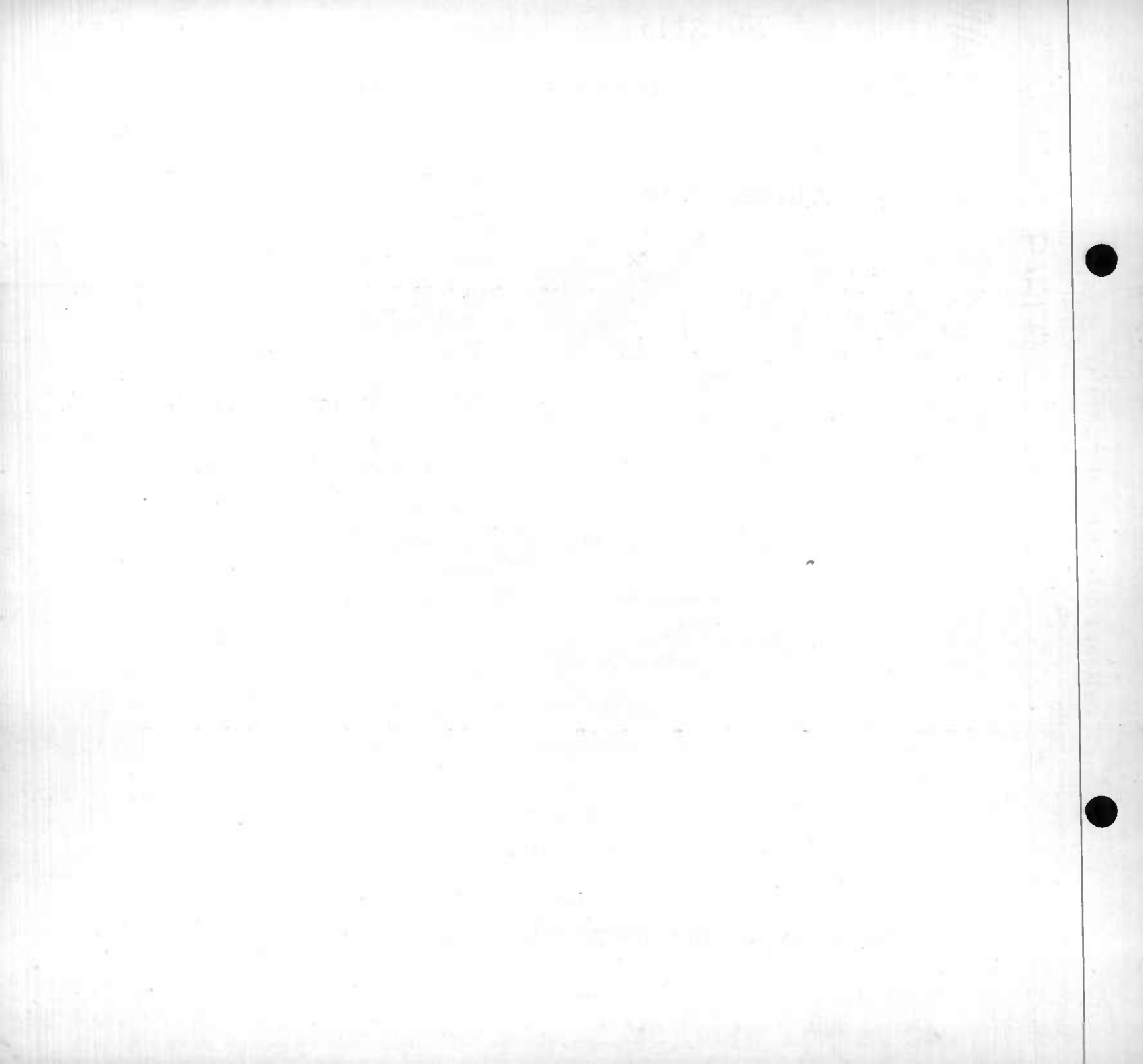
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-600 70 3144		70 3144	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LEE MOORE</b>		3/21/70 7:50 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>326 E. LANVALE STREET</b>			
5. SEX <b>Female</b>	6. RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>04-13-07</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>62</b>	11. BIRTHPLACE (State or foreign country) <b>Hampton N.C.</b>
10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Mc Coy</b>		14. MOTHER'S MAIDEN NAME <b>Ethel</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Waisy B. Charles Portsmouth Va.</b>		ADDRESS	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>INTRACEREBRAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HASCVD</b> (B) _____ (C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>3/21</b> 19 <b>70</b> to <b>3/21</b> 19 <b>70</b> , that (we) last saw the deceased alive on <b>3/21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Karl J. Kramer M.D.</b>		23B. DATE SIGNED <b>3/21/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>KARL J. KRAMER</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <b>Burial 3-25-70 Mt Auburn Cat</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>	
25C. FUNERAL DIRECTOR <b>Clayton Wilson</b>		ADDRESS <b>1020 B. County Dr</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3145</span>	
S-350 70 3145 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LULA VIOLA SETTAN		March 21, 1970 11:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Md. 2631		
4614 White Ave			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4614 White Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 2, 1893	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Baltimore, Maryland U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John F. Turner, Sr.			Emma Stiffler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Kathryn Weber - 4614 White Ave	
18. <span style="font-size: 1.5em;">440.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			cardiac failure 48hrs -		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <del>Arteriosclerotic cardiovascular disease</del> 10 yrs.		
			(C) <del>chronic ashme</del> Lifelong -		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">1-21</span> 1970 to <span style="font-size: 1.5em;">3-21</span> 1970, that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">1-21</span> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (WE) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<span style="font-size: 1.5em;">Stanley B. Klitanowicz MD</span>			3-23-70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
STANLEY B. KLITANOWICZ MD			8121 Loch Raven Blvd. Baltimore, Md. 21204		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		March 25, 1970		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 25 1970		<span style="font-size: 1.5em;">Robert E. Taylor MD</span>		<span style="font-size: 1.5em;">Thelma A. Hoffmann</span> 3218 Nidam St.	





B-620 70 3146 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3146

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PAULINE BOWERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 811 St. Paul St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 22 70 3:30 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1101	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-31-1916 53		10. AGE (In years lost birthday) 53		E. STREET AND NUMBER 811 St. Paul St.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME C. W. RUBSAM	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		14B. KIND OF BUSINESS OR INDUSTRY -		15. MOTHER'S MAIDEN NAME DOROTHY TALLCOT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. -		18. INFORMANT Mrs C. W. Tallcot - Jeffersonville, Vermont.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-23-70	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 3/25/70		24C. NAME OF CEMETERY or CREMATORY LODOWAN PARK CREMATORY	
24D. LOCATION (City, town, or county) (State) BALTO, MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Hoffmann Funeral Home - 3218 Hudson St.		25D. ADDRESS			

Letter from M.E.'s office

4-2-70

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3147</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-122</span> <span style="font-size: 1.5em;">70 3147</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
BIRTH NO. <span style="float: right;">M.</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Vincentina Savickas</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">March 23 1970</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">34 Bon Secours Hospital</span>			A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">1903</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <span style="font-size: 1.2em;">1705 Hollins St</span>		
5. SEX. <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-22-1922</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">47</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Bakery</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Baker</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Lithuania</span>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <span style="font-size: 1.2em;">Joseph Norvaisas</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">—</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216 30 7757</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Vytautas Savickas 1705 Hollins St</span>	
18. <span style="font-size: 1.5em;">174 X I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">myocardial heart,</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">relatives, with metastasis</span>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) <span style="font-size: 1.2em;">Severe demystritis</span>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 19</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">mar 19</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 19</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">James N. Cianos M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3/24/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JAMES N CIANOS, M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">3350 WILKENS AVE-BALTO., MD. 21229</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3-25-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Balto Md</span>		24E. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 25 1970</span>			
25A. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor M.D.</span>		25B. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Thomas J. Keppner Inc</span>		25C. ADDRESS <span style="font-size: 1.2em;">1600 Hollins St</span>	

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

*[Faint, illegible handwriting at the bottom of the page.]*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-360 70 3148				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3148	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Raphael G Citro Sr</b>				2. DATE AND HOUR OF DEATH <b>March 21, 1970 9:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2744</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3102 Echodale Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1920</b>		9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Post Office</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Palmerino Citro</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Del Judice</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>220-03-9901</b>		17. INFORMANT <b>Mrs Marie A Citro</b>		ADDRESS <b>Same</b>	
18. <b>4109 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>7 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>None</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-21-1958</b> to <b>3-21-70</b> 19_____, that (I) (we) lost saw the deceased alive on <b>3-21-70</b> 19_____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (We) (did) <b>did not</b> view the body after death.							
23A. SIGNATURE <b>Wm J. Vitale mrs</b>				23B. DATE SIGNED <b>3-23-70</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>William J Vitale M.D</b>				23D. ADDRESS <b>6800 Loch Raven Blvd. Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Most Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME of REGISTRAR <b>Robert E. J. [illegible]</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>		ADDRESS	

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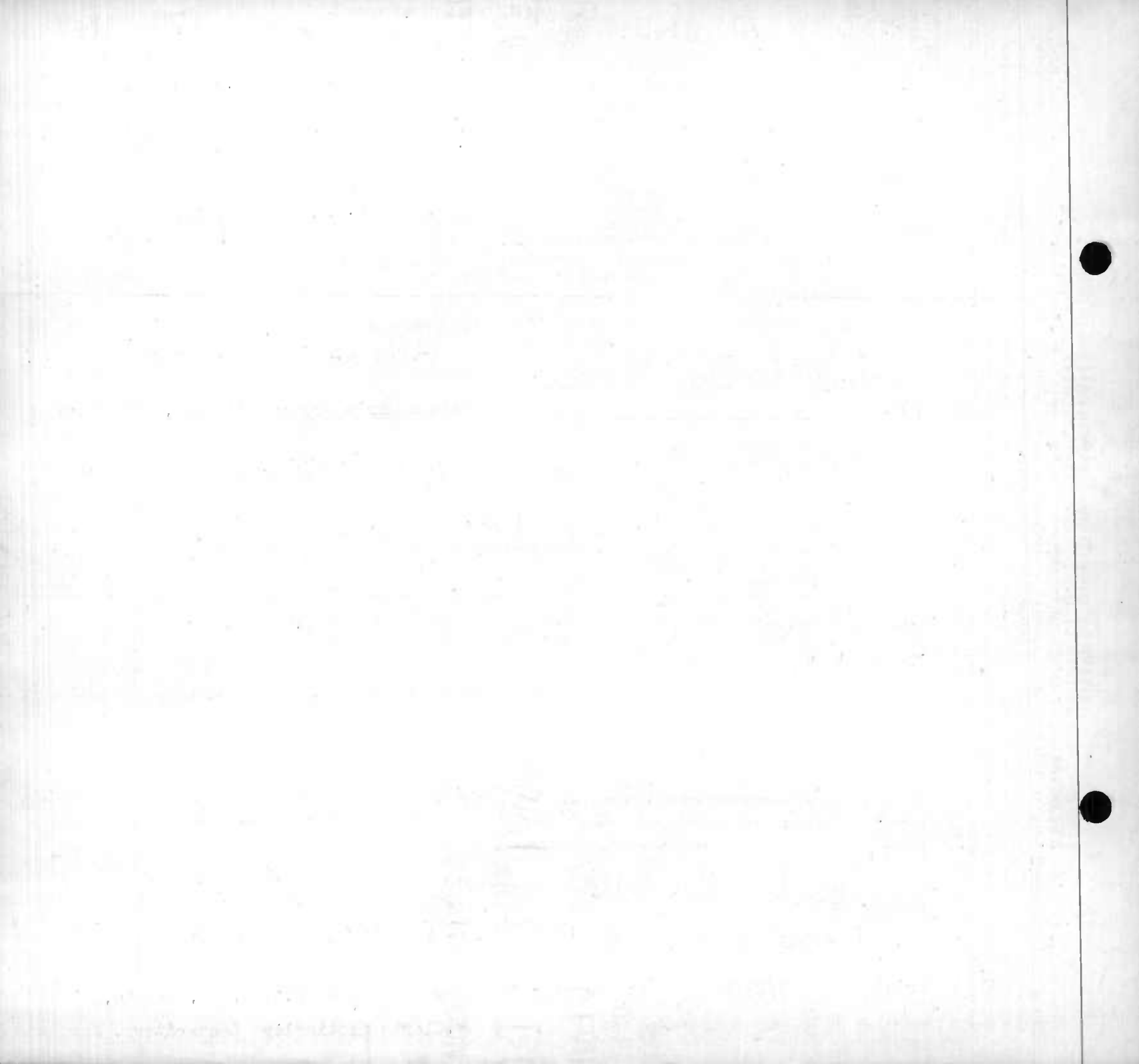
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
G-650		70 3149		70 3149	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Sterling Greene Jr</i>			2. DATE AND HOUR OF DEATH <i>3/20/70 9 AM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>ST MARYS</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> <i>33</i>			C. CITY OR TOWN <i>General Delivery, Compton</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>♂ M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/27/59</i>	9. AGE (In years lost birthday) <i>10</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Sterling Greene</i>			14. MOTHER'S MAIDEN NAME <i>Helena Price</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT ADDRESS <i>Helena Marie Greene Compton, Maryland</i>		
18. <i>207.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Possible sepsis</i> (B) <i>Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Bone marrow depression</i>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>3/16</i> 19 <i>70</i> to <i>3/20</i> 19 <i>70</i> . that (I) ( <del>we</del> ) last saw the deceased alive on <i>3/20</i> 19 <i>70</i> and that in (my) ( <del>an</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.					
23A. SIGNATURE <i>David Valle MD</i> DEGREE			23B. DATE SIGNED <i>3/20/70</i>		23C. PHYSICIAN'S NAME (Type) <i>DAVID VALLE M.D.</i> DEGREE
23D. ADDRESS <i>Johns Hopkins Hospital</i>			24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>3/23/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>St Aloysius Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Leonardtown, St. Mary's, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 25 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR ADDRESS <i>W. Clarke Mattingley Leonardtown, Maryland</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-526 70 3150		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3150	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ABNER J. WENGER</b>		2. DATE AND HOUR OF DEATH <b>3/23/70 5:15 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>2841</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3807 Gwyn Oak Ave</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>3807 GWYNN OAK AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 21-1889</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>Isaac B. Wenger</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH OVERHALZER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-36-9856</b>		17. INFORMANT ADDRESS <b>EMMA JANE WENGER</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Atherosclerosis</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>Blind Infarction of Eye</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 19 67</b> to <b>March 23 19 70</b> , that (I) (we) last saw the deceased alive on <b>March 22 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas G. Abbott</b>				23B. DATE SIGNED <b>3-23-1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott</b>				23D. ADDRESS <b>4509 Liberty Heights Rd</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>3-26-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Spring Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Shippensburg, Pa. 17257</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>			
25B. NAME OF REGISTRAR <b>Barbara K.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Shippensburg Pa</b>			

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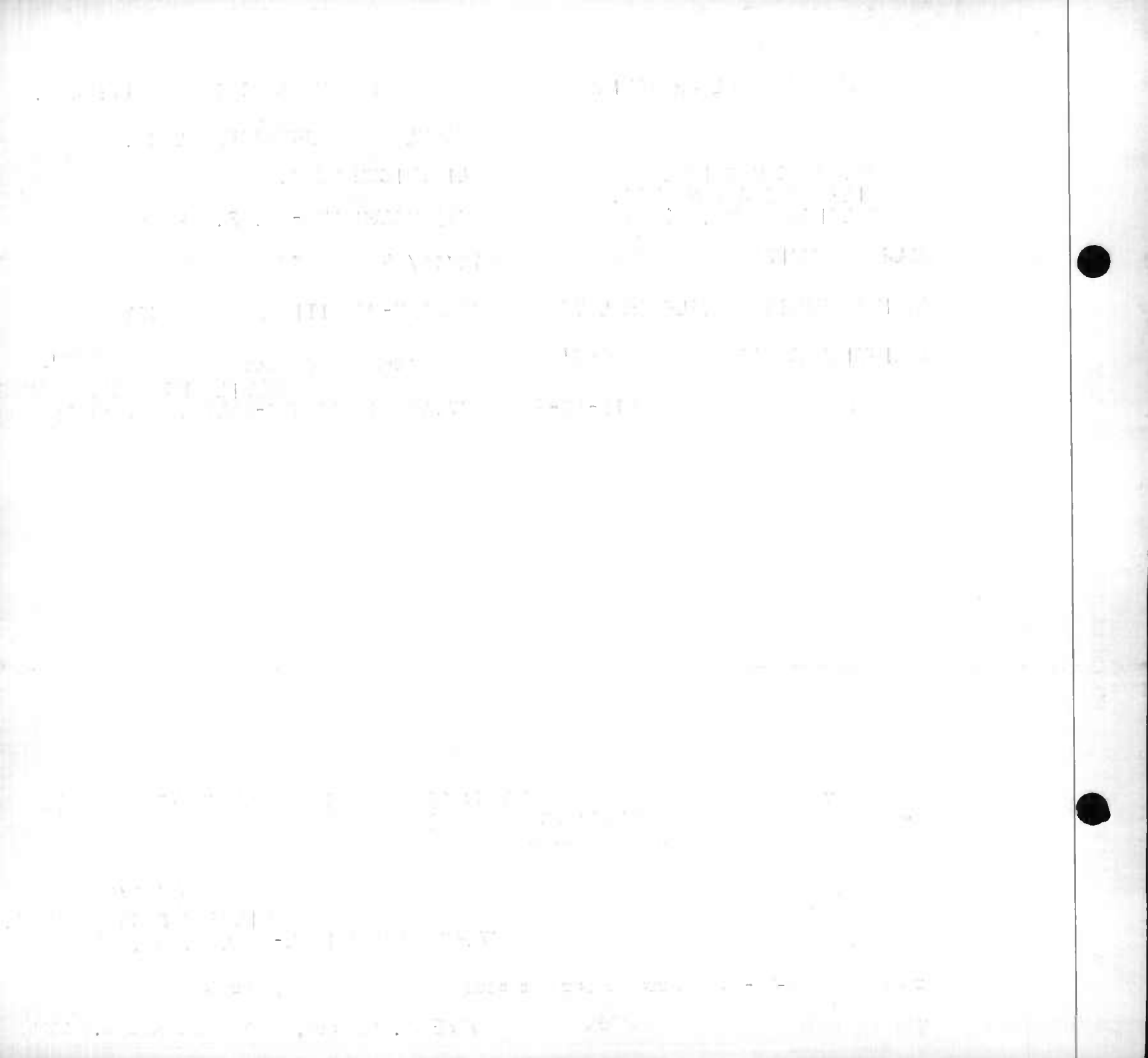
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

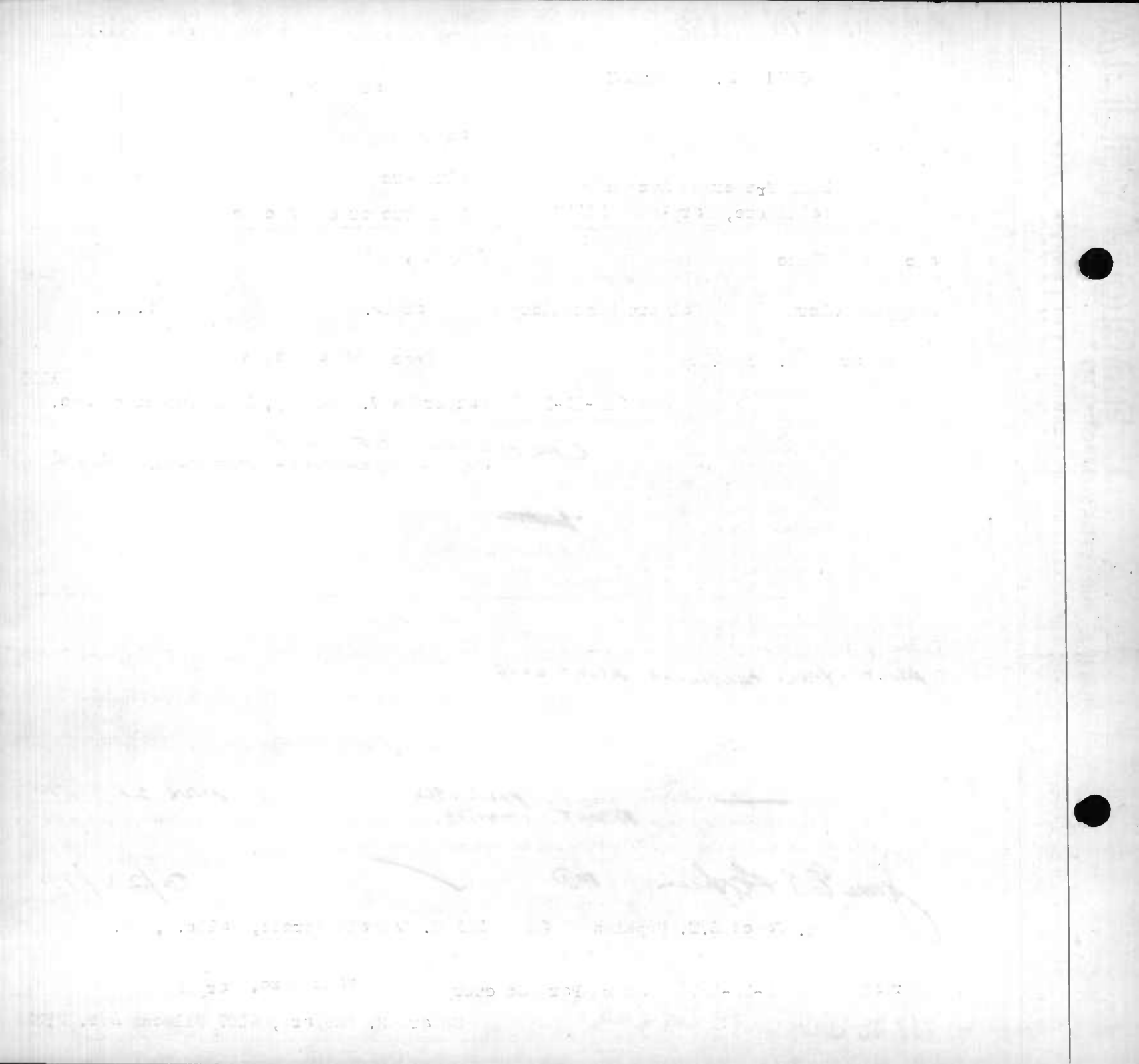
BALTIMORE CITY HEALTH DEPARTMENT				70 3151		X REG. NO. _____	
BIRTH NO. <u>K-620</u>		70 3151		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>KRESS, CARL FREDERICK</u>				2. DATE AND HOUR OF DEATH <u>MARCH 23, 1970</u>   <u>11:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL CO. 5200</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u> <u>WILKENS &amp; CATON AVES.</u> <u>BALTIMORE, MD. 21229</u>				C. CITY OR TOWN <u>LINTHICUM HGTS.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>513 HEATH AVE - P.O. BOX 26</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/04</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY-US CITIZEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN KRESS</u> DEC'D				14. MOTHER'S MAIDEN NAME <u>Karolyn Stiegler</u> DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-6360</u>		17. INFORMANT ADDRESS <u>WILKENS &amp; CATON AVES</u> <u>ST. AGNES RECORDS-BALTO., MD. 21229</u>			
18. <u>410.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute coronary thrombosis</u> <u>e malignant arrhythmia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>MARCH 23, 1970</u> to <u>MARCH 23, 1970</u> that <u>(1)</u> (we) last saw the deceased alive on <u>MARCH 23, 1970</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ching Hui Tsai, M.D.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>03/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ching Hui Tsai, M.D.</u> DEGREE				23D. ADDRESS <u>WILKENS &amp; CATON AVES.</u> <u>ST. AGNES HOSPITAL - BALTO., MD. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-26-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 25 1970</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

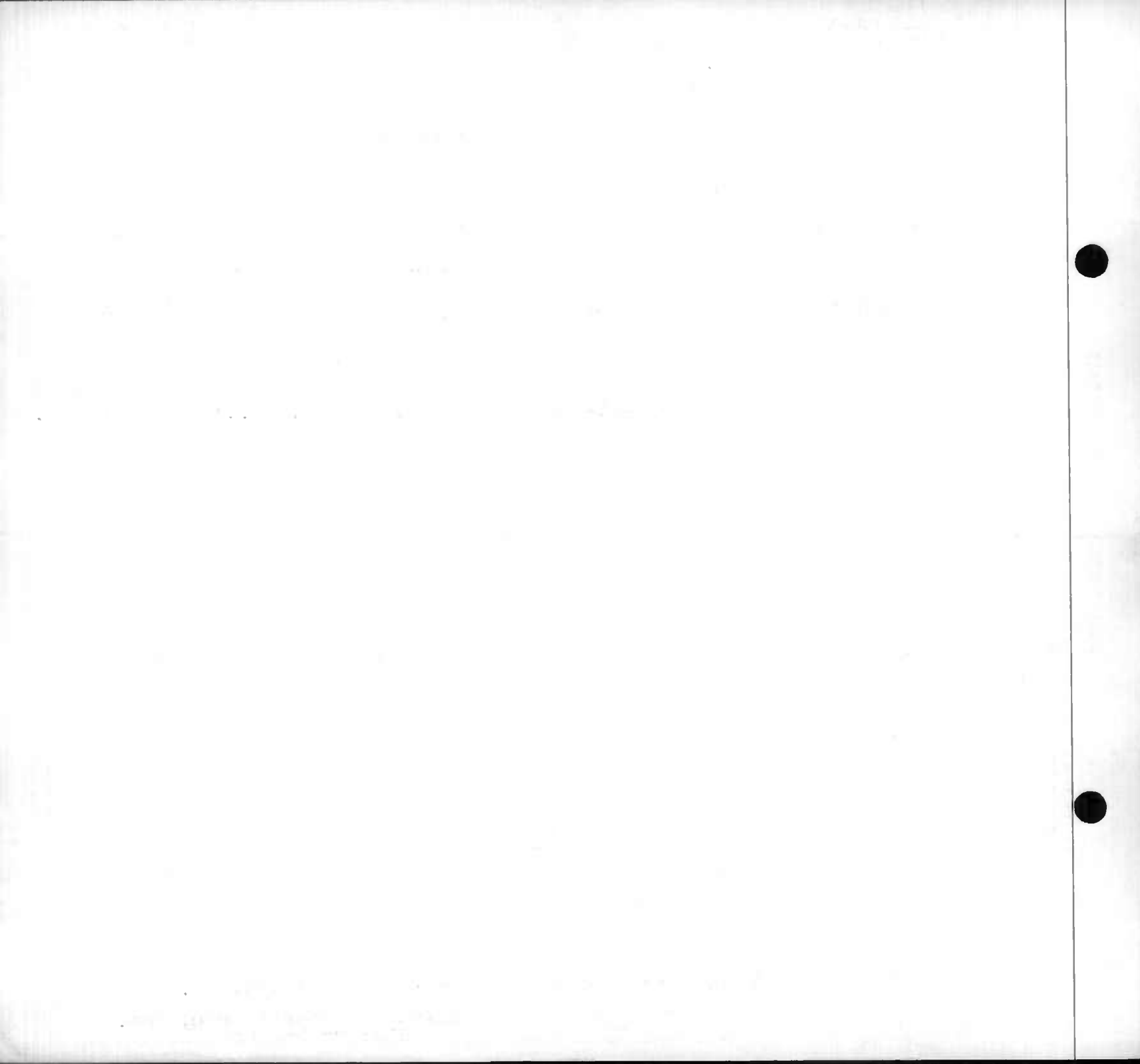
B-240 70 3152				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3152	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN A. BUCKLEY				2. DATE AND HOUR OF DEATH March 21, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2815 Frederick Avenue Baltimore, Maryland 21223				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2006 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2815 Frederick Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1922		9. AGE (In years last birthday) 47	11. BIRTHPLACE (State or foreign country) Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Calvert Distillery		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edgar W. Buckley				14. MOTHER'S MAIDEN NAME Rose Maie Sheldon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-12-3641		17. INFORMANT Catherine V. Buckley, 2815 Frederick Ave.		ADDRESS 21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION ABOUT 1 YEAR 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA RIGHT LUNG 19C. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH CARCINOMA OF LUNG (A) IMMEDIATE CAUSE WITH MEDIASTINAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YR.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAR 1968 to MAR 21 1970, that (I) (we) last saw the deceased alive on ABOUT 1 MONTH, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James E. T. Hopkins M.D. DEGREE				23B. DATE SIGNED 3/23/70		23C. PHYSICIAN'S NAME (Type) Dr. James E. T. Hopkins	
23D. ADDRESS 205 W. Lanvale Street, Balto., Md.				23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-26-1970		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3153</span>	
L-430 70 3153		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Sarah Lewald</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-23-1970</span> <span style="float: right;">6-30 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">37 Mercy Hospital</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">26 33</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">3314 RAMONA AVE.</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11-29-05</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">64</span>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">at home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PENNSYLVANIA</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">JOHN DURRY</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-01-0064D</span>		17. INFORMANT <span style="font-size: 1.2em;">Harry J. Lewald, Jr., 1302 Kenton Rd.</span>	
18. <span style="font-size: 1.5em;">412.4</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <span style="font-size: 1.2em;">A.S.C.U.H.D. L.B.B.</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">2) Pneumonia</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-4 1970</span> to <span style="font-size: 1.2em;">3-23 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-22 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">H. MAKPOUR</span>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HOUSHANG- MAKPOUR</span>	
23D. ADDRESS <span style="font-size: 1.2em;">MERCY HOSPITAL</span>		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/26/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 25 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span>		25D. ADDRESS <span style="font-size: 1.2em;">3331 Brehms Lane</span>		25E. ADDRESS	





1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Virginia CATHERINE V. GILES		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER		F. FATHER'S NAME	
00 4602 Clareway		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4602 Clareway		Wilbur Garey	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/21/1912		57	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Baltimore, Md.		U.S.A.		Mary Watts		Houswife		at home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		215-14-7699		Walter Giles, husband, above		412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hypertensive & cerebral cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
0				no				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		23.			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Russell S. Fisher, M.D.				DATE SIGNED		3-23-70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3/25/70		Loudon Park Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
MAR 25 1970		Robert E. Fisher, M.D.		Schimunek Funeral Home, Inc.		3331 Brehms Lane			

MEMORANDUM FOR THE DIRECTOR, FBI

RE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

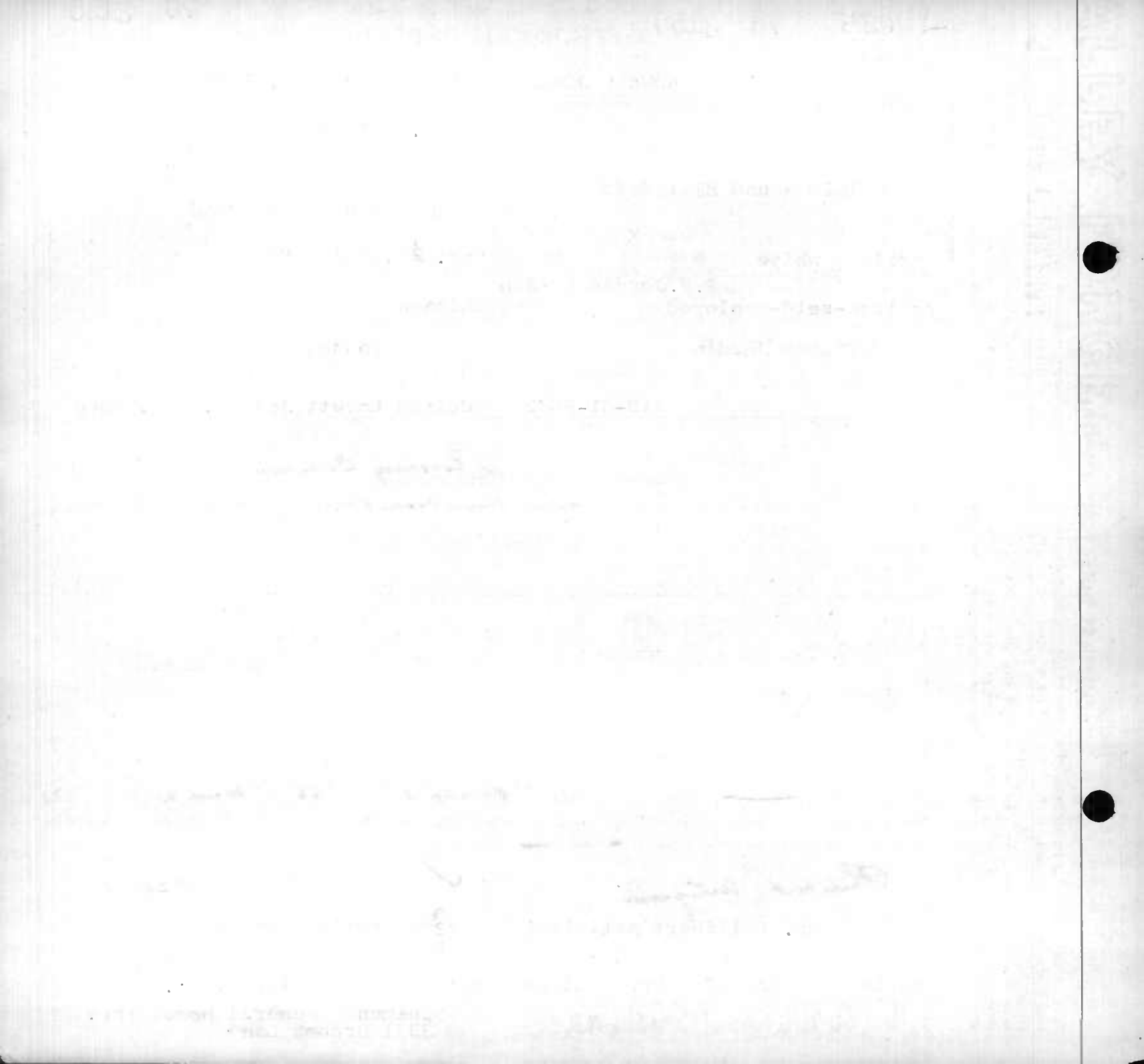
4. [Illegible]

5. [Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

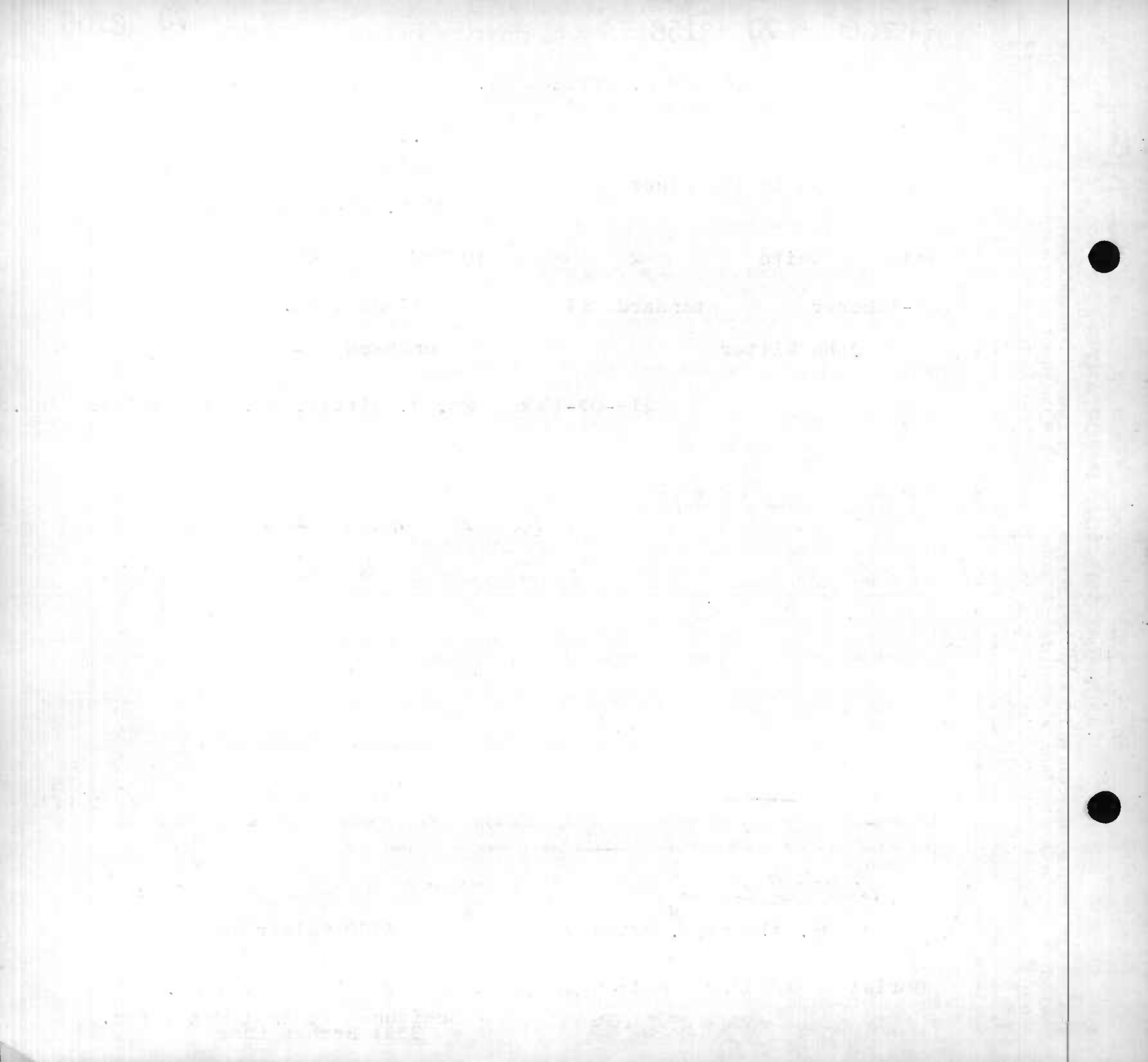
BIRTH NO. <span style="float: right;">70 3155</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">3155</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ROBERT EDWARD JORDAN				March 21, 1970 7 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
1628 Round Hill Road				Md., 21218			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH		9. AGE (In years last birthday)	
male white				Mar. 28, 1881		88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
R.E. Jordan & Assn retired-weld-employed				Chicago			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Jordan				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				212-01-5542		Adeline Lovett Jordan, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from October 31 1966 to March 21 1970, that (I) (we) last saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Philibert Artigiani				3/23/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Philibert Artigiani				2305 Mayfield Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/24/70		Druid Ridge Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 25 1970		Robert E. Taylor, M.D.		Schimunek Funeral Home, Inc.		3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-360</b>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3156</b>			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
<b>JOSEPH J. RITTER, SR.</b>				<b>March 22, 1970</b>				<b>3 45 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 House in the Pines</b>				A. STATE <b>Md., 21224</b>				B. COUNTY <b>601</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>403 N. Streeper Street</b>							
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/89</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret-laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME <b>John Ritter</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-07-1096</b>				17. INFORMANT. ADDRESS <b>Wm. J. Ritter, son, 4314 Hamilton Ave.</b>			
18. <b>41231</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Arteriosclerotic Heart Disease</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>we</del> ) attended the deceased from <b>3/21/1970</b> to <b>3/22/1970</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>3/21/1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.											
23A. SIGNATURE <b>Dr. Albert B. Bradley</b>				23B. DATE SIGNED <b>3/23/70</b>							
23C. PHYSICIAN'S NAME (Type) <b>Dr. Albert B. Bradley</b>				23D. ADDRESS <b>4900 Belair Road</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3/25/70</b>				24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>				25B. NAME OF REGISTRAR <b>26-EE Feb 22 1970</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			

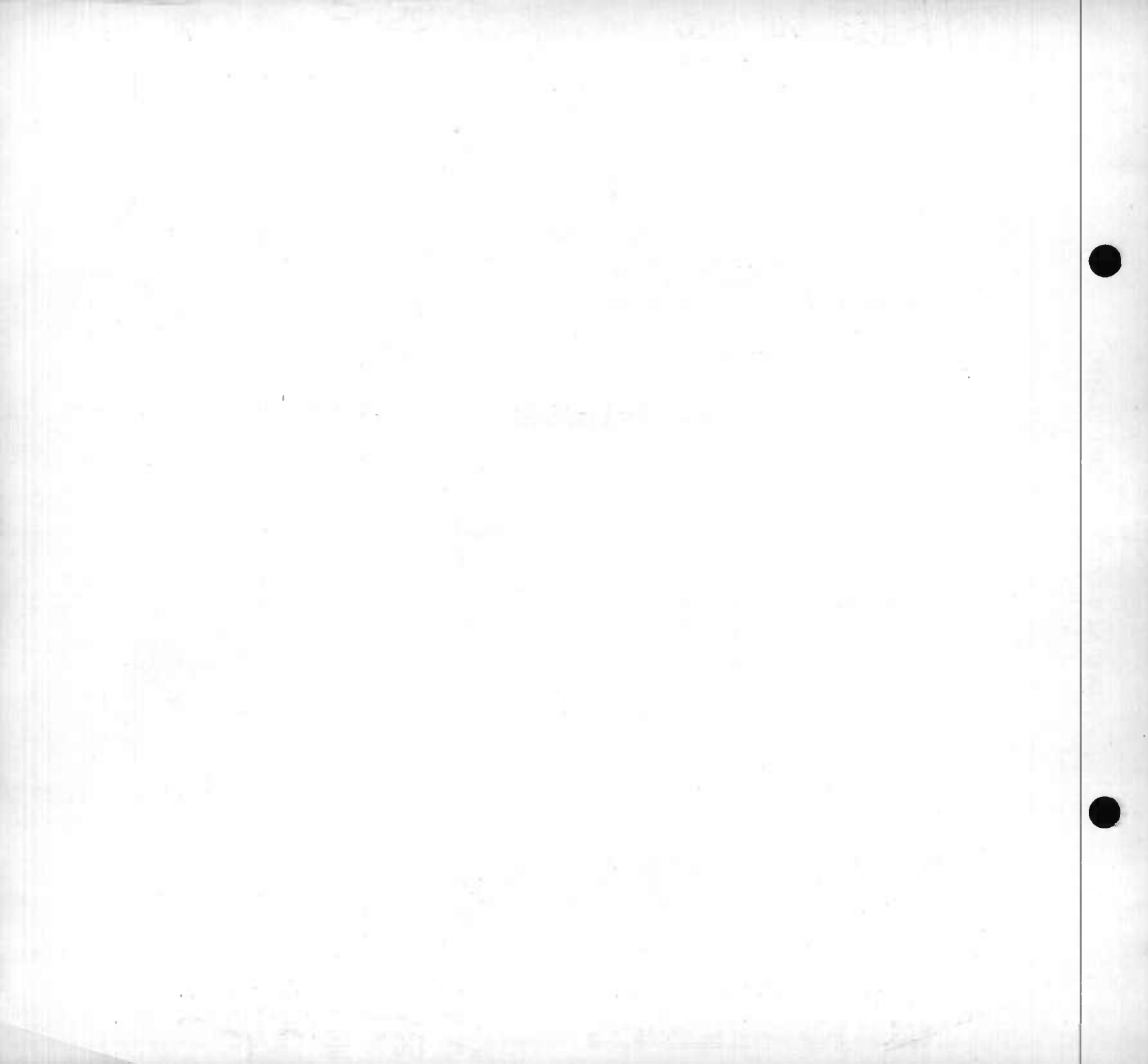


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3157</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">N-352 70 3157</span> <span style="font-size: 1.5em;">70 3157</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<div style="text-align: center;"> <span style="font-size: 1.5em;">Frances</span>  <span style="font-size: 1.5em;">VIRGINIA NITTINGER</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">3/21/70</span> <span style="font-size: 1.5em;">12 P</span> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
<div style="text-align: center;"> <span style="font-size: 1.5em;">MARYLAND GEN. HOSPITAL</span>  <span style="font-size: 1.5em;">827 Linden Ave Baltimore</span> </div>			<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. STATE  <div style="text-align: center;"> <span style="font-size: 1.5em;">4807</span>  <span style="font-size: 1.5em;">Baltimore</span> </div> </div> <div style="width: 50%;"> B. COUNTY  <div style="text-align: center;"> <span style="font-size: 1.5em;">Aberdeen Ave</span>  <span style="font-size: 1.5em;">21206</span> </div> </div> </div>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			<div style="text-align: center;"> <span style="font-size: 1.5em;">Baltimore</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>YES <input checked="" type="checkbox"/></span> <span>NO <input type="checkbox"/></span> </div>
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<div style="text-align: center;"> <span style="font-size: 1.5em;">female</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">white</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>WIDOWED <input type="checkbox"/></span> <span>DIVORCED <input type="checkbox"/></span> </div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<div style="text-align: center;"> <span style="font-size: 1.5em;">Housewife</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">at home</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">Maryland</span> </div>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<div style="text-align: center;"> <span style="font-size: 1.5em;">Frank Smith</span> </div>			<div style="text-align: center;"> <span style="font-size: 1.5em;">unknown</span> </div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		<div style="text-align: center;"> <span style="font-size: 1.5em;">214-14-9358A</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">Ernest T. Nittinger, husband, above</span> </div>	
18. <span style="font-size: 1.5em;">394.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<div style="text-align: center;"> <span style="font-size: 1.5em;">Congestive Heart Failure</span> </div>					
<div style="text-align: center;"> <span style="font-size: 1.5em;">Antiral valvular Disease</span> </div>					
<div style="text-align: center;"> <span style="font-size: 1.5em;">Rheumatic Heart Disease</span> </div>					
<div style="text-align: center;"> <span style="font-size: 1.5em;">II</span> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<div style="text-align: center;"> <span style="font-size: 1.5em;">0</span> </div>				<div style="text-align: center;"> <span style="font-size: 1.5em;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</span> </div>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				<div style="text-align: center;"> <span style="font-size: 1.5em;">21F. HOW DID INJURY OCCUR?</span> </div>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">3/11</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">3/21</span> 19 <span style="font-size: 1.5em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">3/21</span> 19 <span style="font-size: 1.5em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<div style="text-align: center;"> <span style="font-size: 1.5em;">Unique, A.</span> </div>				<div style="text-align: center;"> <span style="font-size: 1.5em;">3/21/70</span> </div>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<div style="text-align: center;"> <span style="font-size: 1.5em;">ENRIQUE, A.</span> </div>				<div style="text-align: center;"> <span style="font-size: 1.5em;">Maryland GEN. Hosp.</span> </div>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<div style="text-align: center;"> <span style="font-size: 1.5em;">Burial</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">3/24/70</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">Baltimore Cemetery</span> </div>	
				<div style="text-align: center;"> <span style="font-size: 1.5em;">Baltimore, Md.</span> </div>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<div style="text-align: center;"> <span style="font-size: 1.5em;">MAR 25 1970</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">Robert E. Fisher, MD.</span> </div>		<div style="text-align: center;"> <span style="font-size: 1.5em;">Schimunek Funeral Home, Inc.</span>  <span style="font-size: 1.5em;">3331 Brehms Lane</span> </div>	

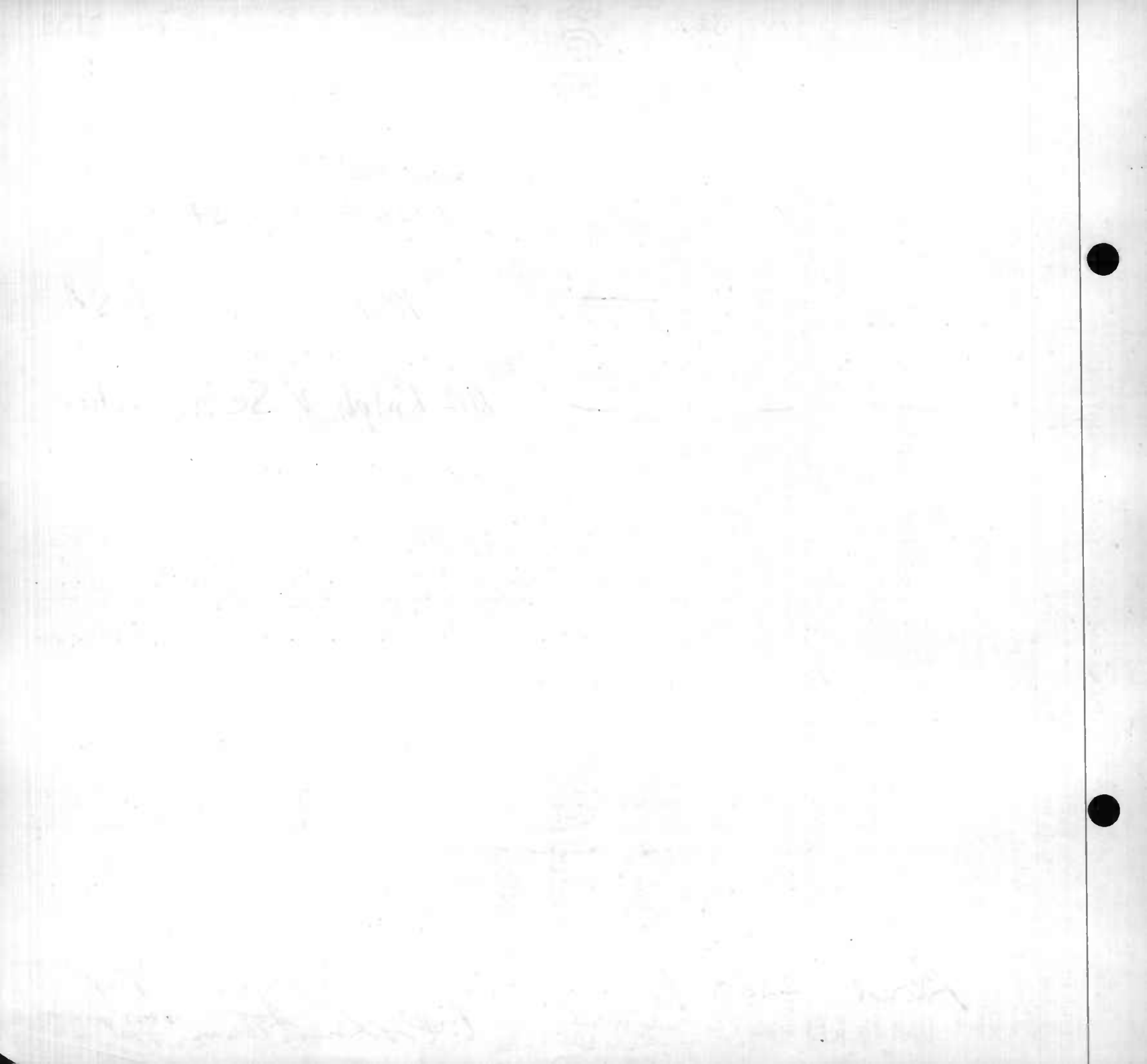






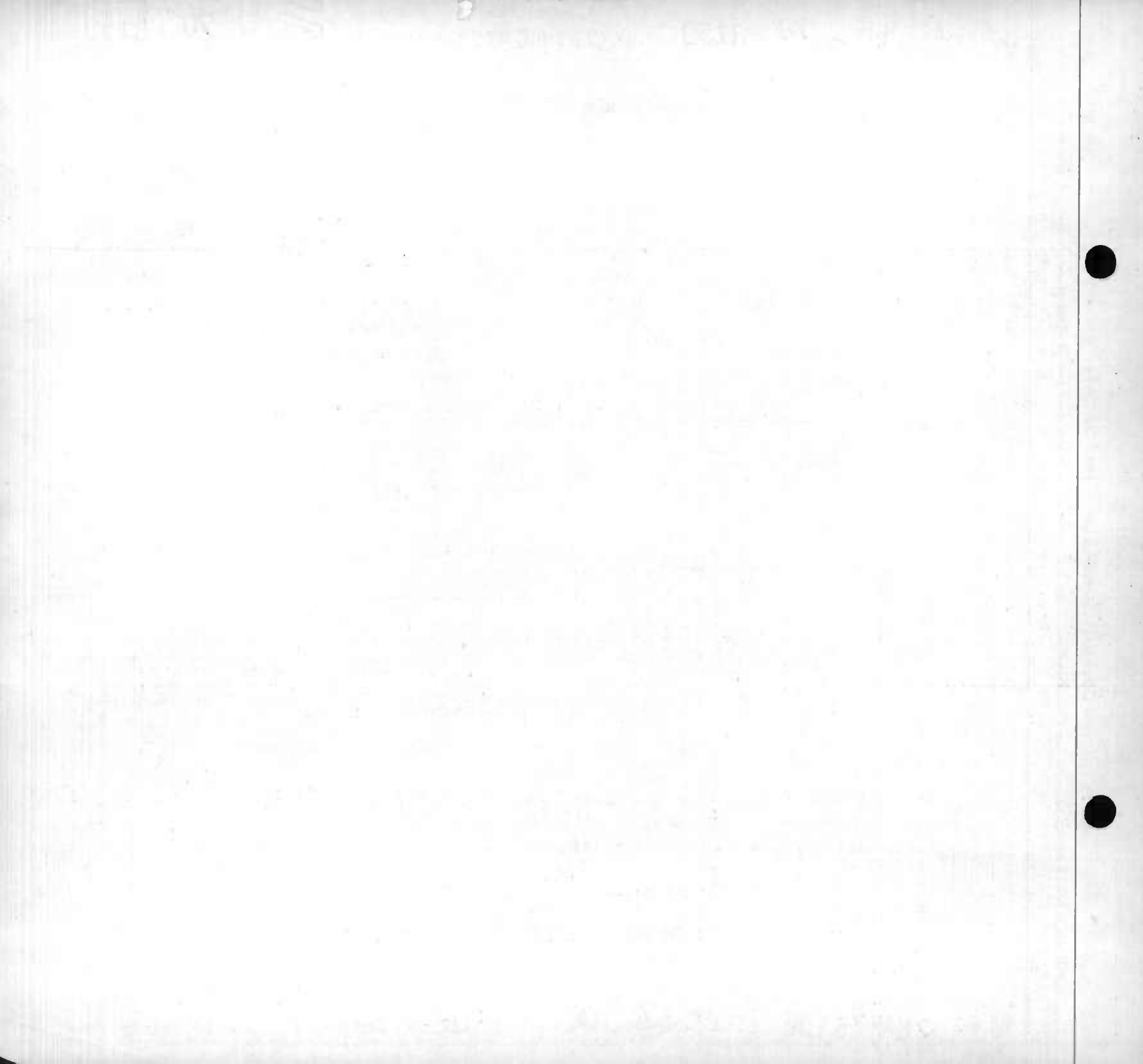
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3159	
W-250 70 3159		BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
JOHN B. WOZNY		March 22, 1970 4 A.M. M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
00 11 S. Janney St.,		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN	
		Maryland		Baltimore	
		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11 S. Janney St.,	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 10, 1905 65		Meat cutter
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Meat		Meat		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Leonard Wozny		Elizabeth Reisinger	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-03-3564		Mrs. Doris Smith 19 N. East Ave., m	
18. 162.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Co of lung			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		Feb 12 1970 to 3/22 1970		and that in (my) (our) opinion death occurred on the date	
that (I) (we) last saw the deceased alive on		3/20 1970		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
J. H. Goodman M.D.		3/23/70		Julius H. Goodman, M.D.	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
9 S. Highland Ave.		Ullrich Funeral Home, 4210 Belair Road.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/24/70		Oak Lawn Cemetery	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Colgate, Md.		MAR 25 1970		Robert E. Taylor, M.D.	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3160</span>	
W-526 70 3160				<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Marie B. Wenger</span>				March 23, 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">43</span> South Balto. Gen. Hospital				A. STATE <span style="font-size: 1.2em;">Maryland</span>	
				B. COUNTY <span style="font-size: 1.5em;">7402</span>	
				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">1442 Henry St.</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9 20 1896</span>		
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">73</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Owner</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Tavern</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Balto. Md.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">William G. Little</span>				12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U S A</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Edith J. Cropper</span>	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. William H. Wenger 1442 Henry St.</span>	
18. <span style="font-size: 1.5em;">23-0.91</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Myocardial Insufficiency</span>					
DUE TO, OR AS A CONSEQUENCE OF:					
(B) <span style="font-size: 1.2em;">Hypertension</span>					
DUE TO, OR AS A CONSEQUENCE OF:					
(C) <span style="font-size: 1.2em;">Diabetes</span>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">August 20</span> 19 <span style="font-size: 1.2em;">61</span> to <span style="font-size: 1.2em;">March 23</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Aug. 6-19 64</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">George E. Shannon MD</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <span style="font-size: 1.2em;">412 medical arts Bldg.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">3 26 70</span>		<span style="font-size: 1.2em;">Oaklawn</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<span style="font-size: 1.5em;">MAR 25 1970</span>		<span style="font-size: 1.2em;">Robert E. Fisher R.D.</span>		<span style="font-size: 1.2em;">Mc Gully 130 E. Fort Ave</span>	

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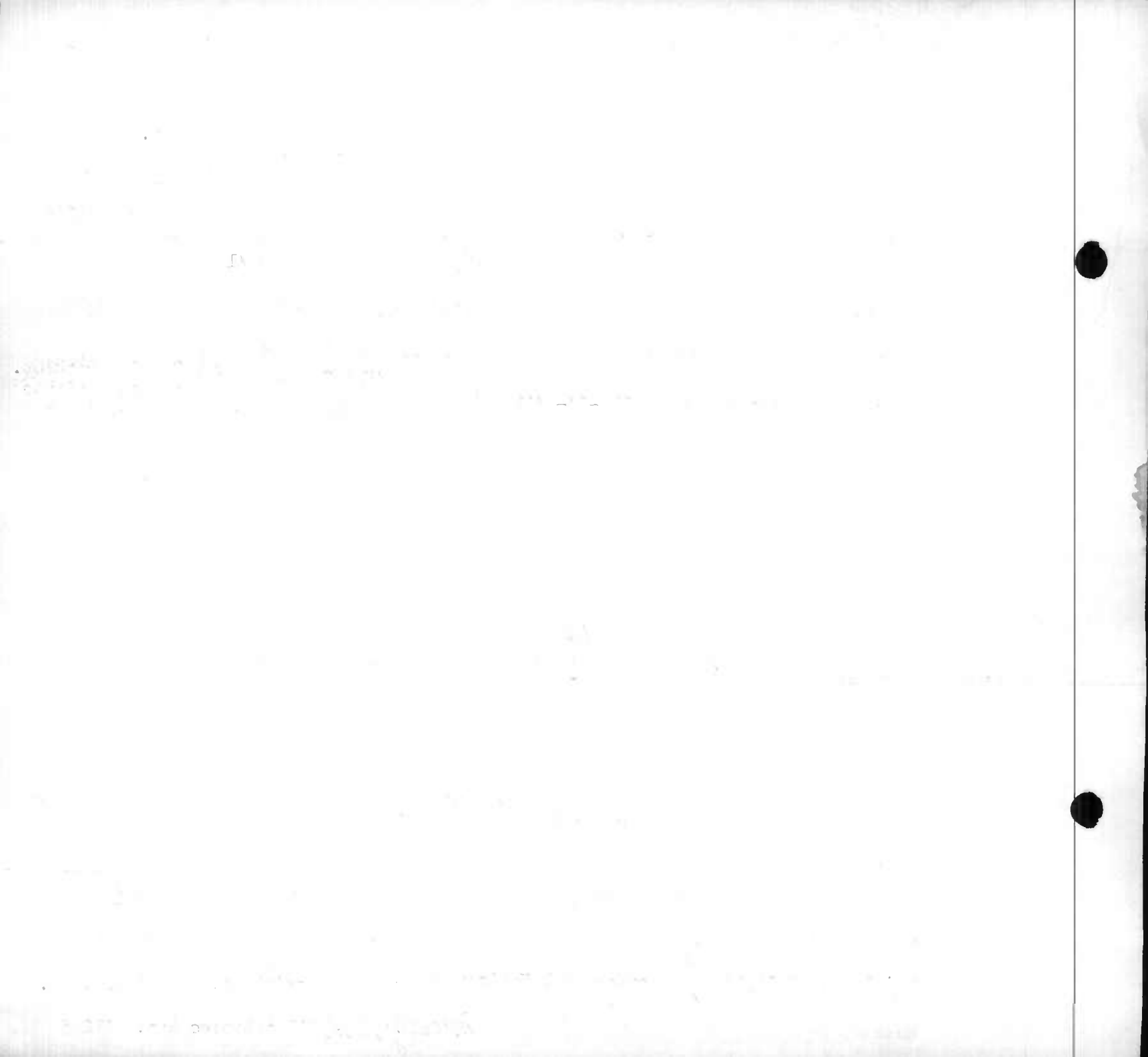
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 3161	
5-432 70 3161				BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Edward Schultz</u>				3/23/70 9 03 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General</u> <u>43</u>				A. STATE <u>MD</u>		B. COUNTY <u>Anne Arundel Co.</u>	
				C. CITY OR TOWN <u>Brooklyn</u>		D. INSIDE CITY LIMITS? <u>XXXXX</u> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>110 2nd Ave Brooklyn Park 21225</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/28</u>		9. AGE (In years last birthday) <u>XXXX 41</u>	10. Under 1 Yr. 11. Under 24 Hrs. 12. Hours 13. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Dept. Mail Handler</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward W. Schultz (dec)</u>				14. MOTHER'S MAIDEN NAME <u>Frieda Lehr</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXXXX Yes Korean War</u>				16. SOCIAL SECURITY NO. <u>216-24-8422</u>		17. INFORMANT <u>Frieda Lehr</u> <u>1779 Highbrook St. Yorktown Heights</u>	
18. <u>400.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Renal Failure</u>				CAUSE OF DEATH <u>10598</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Malignant Hypertension</u>		<u>Weeks</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Marked Congestive Heart Failure</u>						<u>Days</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>70</u> to <u>3/23</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John A. Eaddy M.D.</u>				23B. DATE SIGNED <u>3/28/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>John A. Eaddy M.D.</u>				23D. ADDRESS <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/26/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd. Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 25 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>McCurly F. H.</u>		ADDRESS <u>237 Patapsco Ave. 21225</u>	

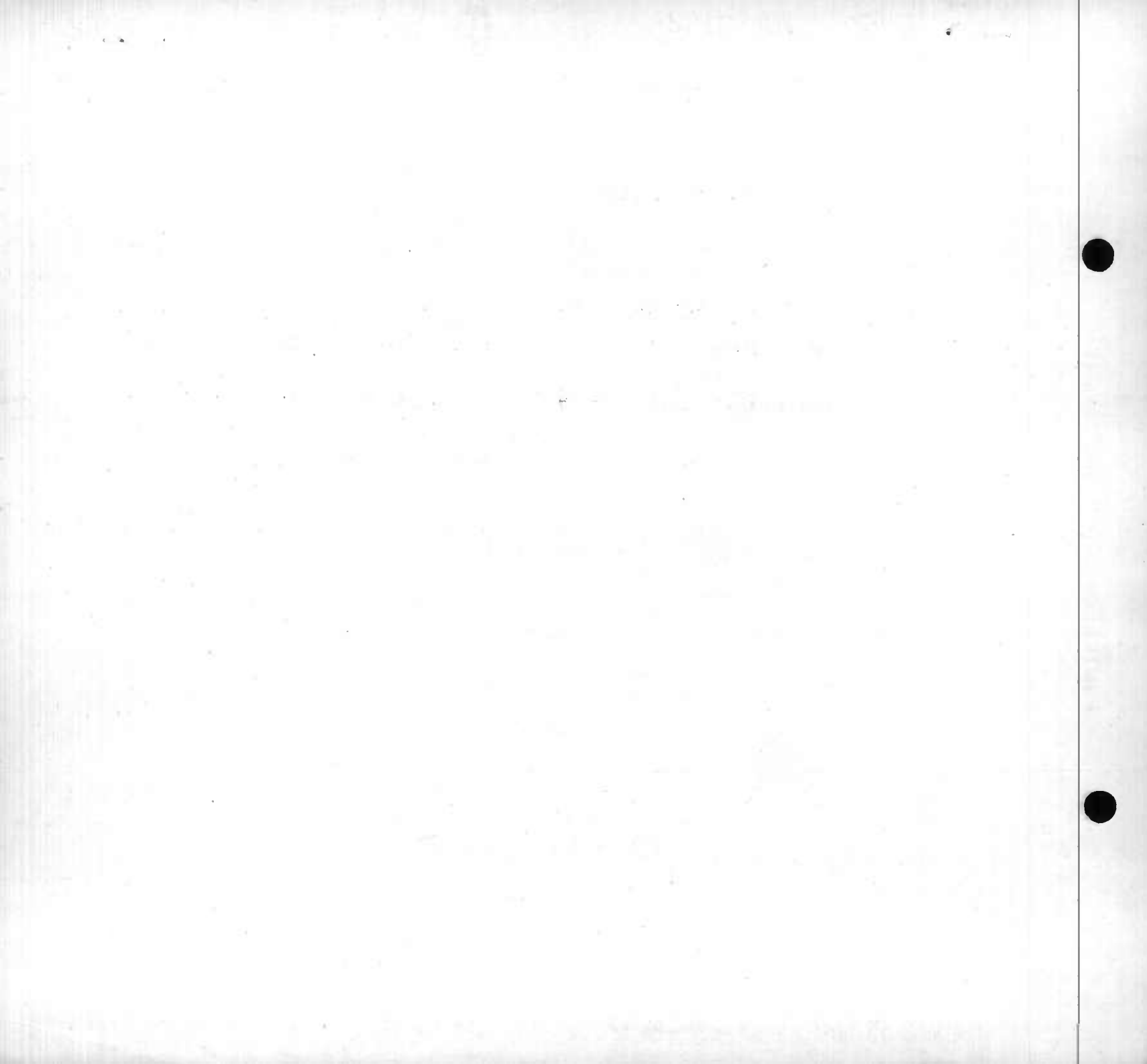




**FUNERAL DIRECTOR: IMPORTANT**

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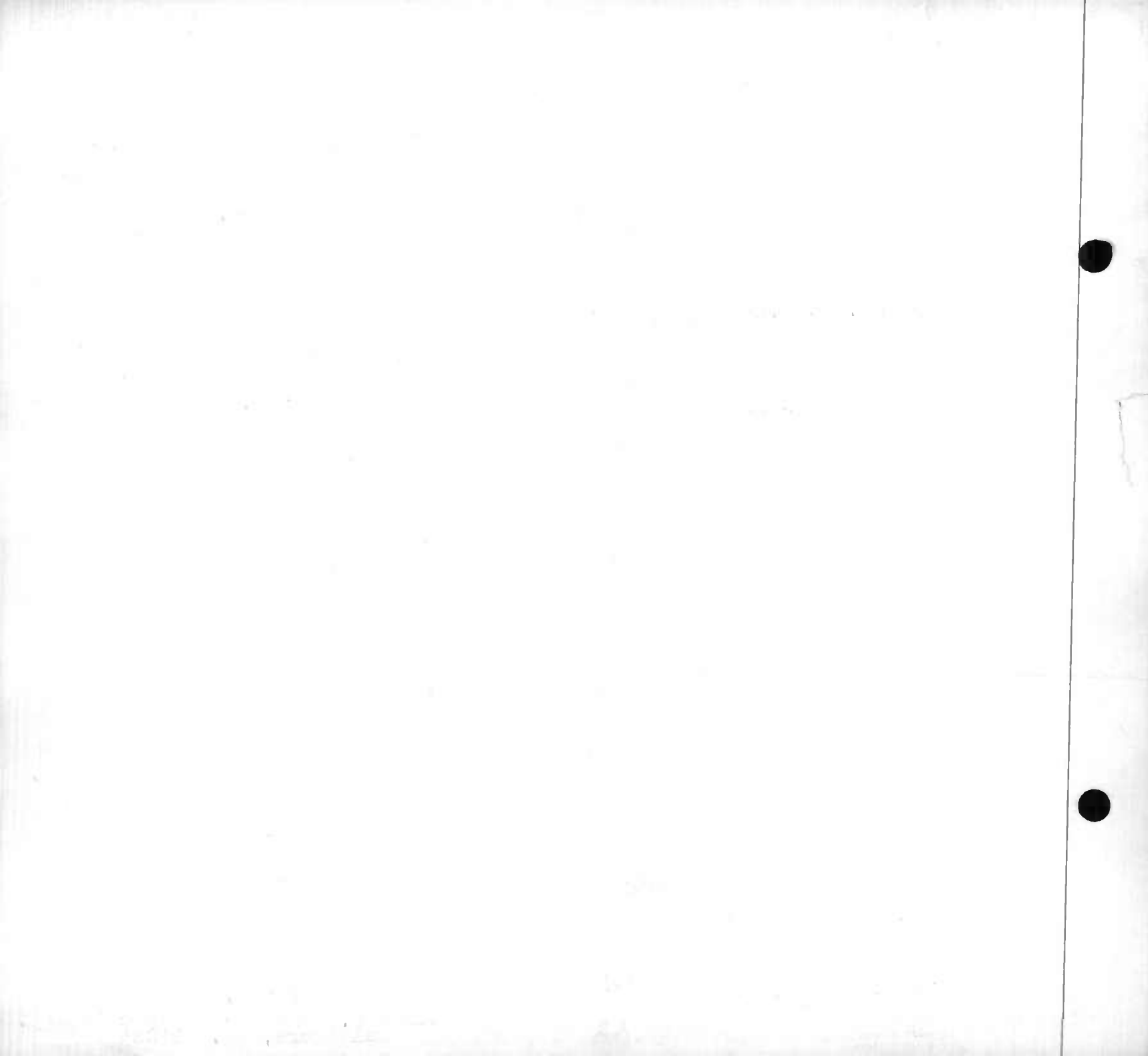
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3162</b>	
<b>K-452 70 3162</b> <b>BIRTH NO.</b>				<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>John Klinger</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>March 21, 1970 11:42 P M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 5316 Nelson Ave. Balto. 21215</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2788</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>5316 Nelson Ave.</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Cau.</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12 9/24/99</b>	<b>9. AGE</b> (In years lost birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Dye Maker</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Dye Craft Inc.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>	
<b>13. FATHER'S NAME</b> <b>Edward Klinger</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Proudfoot</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes XXXXXXXX W.W.1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>194-014744 A</b>		<b>17. INFORMANT</b> <b>Mrs. Geraldine Klinger</b> <b>5316 Nelson Ave.</b>	
<b>18. 436.9 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			<b>CAUSE OF DEATH</b> <b>Cerebro-Vascular Accident</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>Cerebral Arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  <b>Generalized Arteriosclerosis</b> (C)		
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 HRS.</b>  <b>10 YEARS</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>—</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>—</b>	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) <b>—</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>—</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from JAN 1967 to 21 MAR 70 19</b> <b>that (1) (we) last saw the deceased alive on 6 MAR 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Malcolm Druskin MD.</b>			<b>23B. DATE SIGNED</b> <b>23 MAR 70</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Malcolm Druskin MD.</b>
<b>23D. ADDRESS</b> <b>2217 South Road Balto. Md. 21209</b>					
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>3/25/70</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Baltimore, National Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Maryland</b>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 25 1970</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor MD.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Loring Byers</b>	
<b>25D. ADDRESS</b> <b>8428 Liberty Road, Baltimore</b>		<b>25E. ADDRESS</b> <b>21133</b>			



# FUNERAL DIRECTOR: IMPORTANT

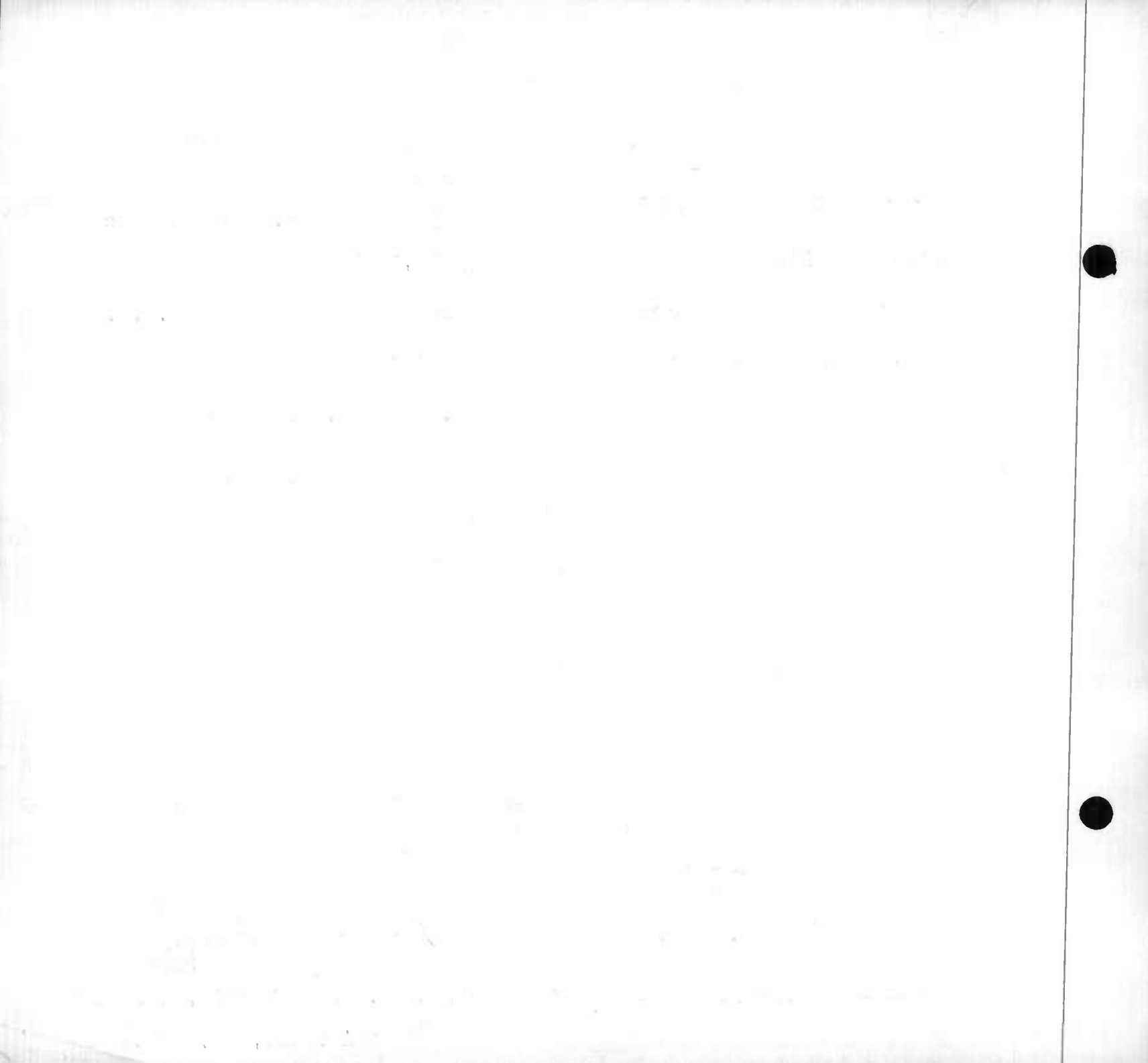
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 3163</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">P-236 70 3163</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">PASTERNAK, ANTHONY Vincent</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">UNIVERSITY OF MARYLAND HOSP.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Anne Arundel</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">109 Carvel Beach Rd.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">6/11/10</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mail Rm. Foreman</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Sunpapers</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">VINCENT PASTERNAK</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">XXXXXXXXX Josephine Skrakowski</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WW II</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">-</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">XXXXXXXXX Geneva S. Pasternak</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">E. coli septicemia</span> (B) <span style="font-size: 1.2em;">Pneumonia, Bronchopneumal fistula</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">RENAL FAILURE</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">3/3/70</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">PULM TUBERCULOSIS</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">NO</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/9/70</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/21</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/21</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Vicente R. Carag Jr. M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/21/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">VICENTE R. CARAG JR M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">UNIVERSITY OF MD. HOSPITAL</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/25/70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Baltimore National</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 25 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">R. E. J. JR.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">George G. Gonce</span>			
<b>25D. ADDRESS</b> <span style="font-size: 1.2em;">4001 Ritchie Hgy. Baltimore, Md. 21225</span>		<b>VS 150-REV. 1/1/68</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 3164	
G-416 70 3164		BIRTH NO.		70 3164		70 3164	
1. NAME OF DECEASED (Type or Print) <b>DOMINICK GILBERTO</b>				2. DATE AND HOUR OF DEATH <b>3/20/70 7:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b> <b>201 St. Paul Place, Balto</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> <b>5200</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Pasadena</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>8434 Garden Rd. Riviera Beach</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1903</b>	9. AGE (in years last birthday) <b>66</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Market</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustine Gilberto</b>				14. MOTHER'S MAIDEN NAME <b>Philomena</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Clara M. Gilberto</b>		ADDRESS <b>Same</b>	
18. <b>342X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Possible myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 ventricular fibrillation D. AS EVD</b> (B) <b>Chronic pyelonephritis probably 20 to 30</b> DUE TO, OR AS A CONSEQUENCE OF: <b>abdominal aortic aneurysm</b> (C) <b>Parkinson's Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Mar. 20 19 70</b> to <b>Mar. 20 19 70</b> that (I) (we) last saw the deceased alive on <b>Mar. 20 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A.T. Hipolito, M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/20/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>A.T. Hipolito, M.D.</b> DEGREE				23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Phyllis J. Fisher</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. Baltimore, Md. 21225</b>	



G-450		70 3165		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3165	
1. NAME OF DECEASED (Type or Print) Lucy M. Giulioni									
2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location) 40 St. Agnes Hospital									
3. DATE PRONOUNCED DEAD Month Day Year Hour 3 20 70 5:45 a. M.									
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300									
6. SEX female		7. RACE white		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH December 19, 1908 61		10. AGE (In years lost birthday) 61		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2826 Michigan Ave.			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DeCarlo					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Information Clerk		14B. KIND OF BUSINESS OR INDUSTRY Hospital		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Francis Giulioni		ADDRESS Same			
19. 412.4 I CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease									
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/20/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/70		24C. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park		24D. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		25B. NAME OF REGISTRAR Robert C. Taylor, M.D.		25C. FUNERAL DIRECTOR George J. Gonca		ADDRESS 4001 Ritchie Hwy. Baltimore, Md. 21225			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3166</span>	
<p><span style="font-size: 1.5em;">P-520</span> <span style="font-size: 1.5em;">70 3166</span></p> <p><b>BIRTH NO.</b></p>		<p><b>CERTIFICATE OF DEATH</b></p>			
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">SARAH V. PHENICIE</span></p>			<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/20/70</span> M.</p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION: <span style="font-size: 1.2em;">00</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">2816 WATERVIEW AVE</span></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE: <span style="font-size: 1.2em;">Baltimore</span> B. COUNTY: <span style="font-size: 1.2em;">md.</span></p> <p>C. CITY OR TOWN: <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER: <span style="font-size: 1.2em;">2816 Waterview Ave.</span></p>		
<p><b>5. SEX</b> <span style="font-size: 1.2em;">F</span></p>	<p><b>6. RACE</b> <span style="font-size: 1.2em;">W</span></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">OCT 5-1879</span></p>	<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">90</span></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span></p>			<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">HOME MAKER</span></p>		
<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span></p>			<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA.</span></p>		
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Robinson</span></p>			<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">SARAH MAHONEY</span></p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span></p>			<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-01-7016</span></p>		
<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Charles W. Chamberlain</span></p>			<p><b>ADDRESS</b></p>		
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">4/12/70 I</span></p>			<p><b>CAUSE OF DEATH</b></p> <p>(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Atherosclerotic c-v-d</span> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <span style="font-size: 1.2em;">YES -</span> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <span style="font-size: 1.2em;">9rs -</span></p>		
<p><b>II</b></p>					
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p>(If in Baltimore City, give exact location)</p>			
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b></p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 14</span> 1969 to <span style="font-size: 1.2em;">March 20</span> 1970, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">JAN 13</span> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span></p>				<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3-23-70</span></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">S. J. VENABLE, JR. M.D.</span></p>				<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">7215 YORK Rd. Baltimore MD</span></p>	
<p><b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span></p>		<p><b>24B. DATE</b> <span style="font-size: 1.2em;">3/23/70</span></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">LOUDEN PARK Ceme.</span></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore md.</span></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 25 1970</span></p>			
<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">[Signature]</span></p>		<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Wm. J. Trkner Sons</span></p>			
<p><b>ADDRESS</b> <span style="font-size: 1.2em;">NORTH + PENNA. AVE.</span></p>		<p><b>VS 150-REV. 1/1/68</b></p>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-650 70 3167				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3167	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Vincent M. Lohran</i>		2. DATE AND HOUR OF DEATH <i>March 20, 1970 8 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>602</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 134 N. Luzerne Avenue</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>134 N. Luzerne Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1908</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Lohran</i>				14. MOTHER'S MAIDEN NAME <i>Marie A. Buocz</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 2</i>		16. SOCIAL SECURITY NO. <i>215-07-4086</i>		17. INFORMANT ADDRESS <i>Josephine G. Lohran 134 N. Luzerne Av</i>			
18. <i>188 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>passive congestion, pulmonary</i> (B) <i>Carcinoma of bladder - metastatic</i> DUE TO, OR AS A CONSEQUENCE OF: (C) -----			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>3-28-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>EA bladder</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3-18</i> 19 <i>70</i> to <i>19</i> 19 <i>70</i> and that (I) (we) lost saw the deceased alive on <i>3-18</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John A. Colston Jr. MD</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>John A. Colston Jr. MD</i>	
23D. ADDRESS <i>3414 St. Paul St. Balto. Md.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/24/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 25 1970</i>		25B. NAME OF REGISTRAR <i>Deane J. A. [illegible]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Morian, Inc. 3000 E. Balto. St.</i>			

Concurrence of labels & notation  
passive comparison, following

5-28-68 CA Baller No

2-18 20

John A. Colston Jr MD MPH St Paul St. Polk MD  
John A. Colston Jr MD MPH St Paul St. Polk MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

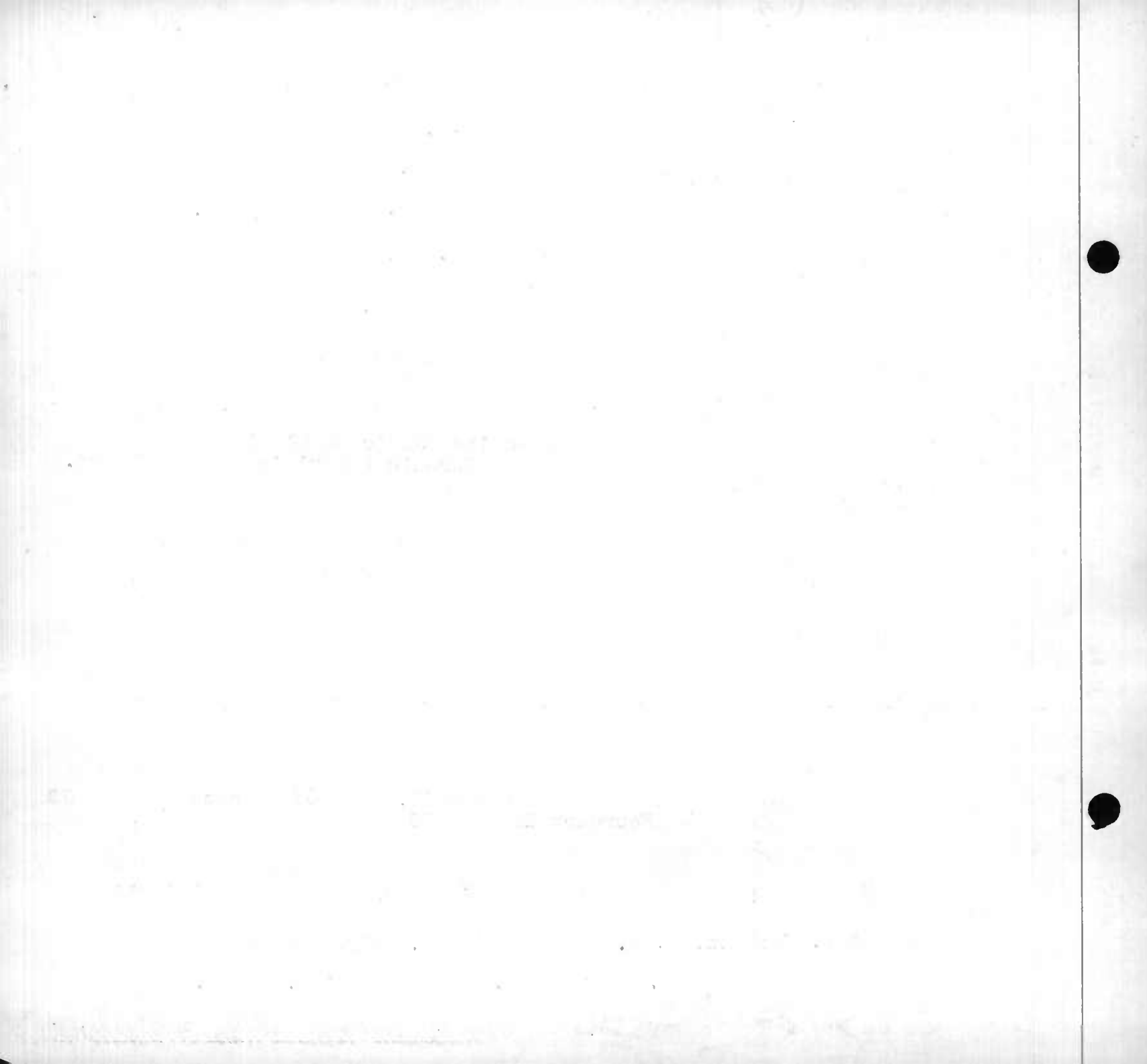
<p><b>1-520</b>      <b>70 3168</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>70 3168</b></p>					
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Bertha Thomas</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>March 22, 1970</b>      <b>10:30 p.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b></p> <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b>      B. COUNTY <b>1403</b></p> <p>C. CITY OR TOWN <b>Baltimore</b>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1834 Pennsylvania Avenue</b></p>			
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. RACE</b> <b>Negro</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>9-15-95</b></p>	<p><b>9. AGE</b> (In years lost birthday) <b>75</b> <sup>7</sup>/<sub>8</sub></p>	<p><b>10. Under 1 Yr.</b> Months Days      <b>11. Under 24 Hrs.</b> Hours Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unemployed</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Florida</b></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>		<p><b>13. FATHER'S NAME</b> <b>Thomas Berry</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Eliza Berry</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b>      <b>ADDRESS</b> <b>Mrs. Nathalee Hall-Neice</b>      <b>1523 Brunt St.</b></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b>      <b>Intracerebral</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>      <b>Hemorrhage</b></p> <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(C)</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p style="text-align: center;"><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>No</b></p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>		<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>March 9,</b> <b>1970</b> <b>to</b> <b>March 22,</b> <b>1970</b> that (I) (we) last saw the deceased alive on <b>March 22,</b> <b>1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p><b>23A. SIGNATURE</b></p> <p><i>[Signature]</i> M.D. DEGREE</p>		<p><b>23B. DATE SIGNED</b> <b>3-23-70</b></p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>O TENBOR</b> M.D. DEGREE</p>	
<p><b>23D. ADDRESS</b> <b>1514 Division Street Balto., Maryland</b></p>		<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>			
<p><b>24B. DATE</b> <b>3/26/1970</b></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <b>W. Auburn Cem.</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Balto., Md.</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 25 1970</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b></p>		<p><b>25C. FUNERAL DIRECTOR</b>      <b>ADDRESS</b> <b>Williams Funeral Home</b>      <b>319 N. Schorley St.</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3169	
<div style="display: flex; justify-content: space-between;"> <span>G-200 70 3169</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>Martha Gough</b>			2. DATE AND HOUR OF DEATH <b>March 22, 1970</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>			A. STATE <b>Md.</b> B. COUNTY <b>1802</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1100 W. Fairmount Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1890</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wren Va.</b>	
13. FATHER'S NAME <b>Nelson Hamlet</b>		14. MOTHER'S MAIDEN NAME <b>Louise Mason</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mabel Jackson 1100 W. Fairmount Ave.</b>	
18. <b>404X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Hypertensive Cardio Renal Disease</b> <b>Chronic Arthritis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 27, 1965</b> to <b>March 1970</b> , that (I) (we) last saw the deceased alive on <b>February 24, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. L. Jackson</b>				23B. DATE SIGNED <b>3/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert L. Jackson, M. D.</b>				23D. ADDRESS <b>600 N. Arlington Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/26/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home 3199 Schrock St</b>	





## FUNERAL DIRECTOR: IMPORTANT

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F-655		70 3170		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3170	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>FREEMAN, THERESA</b>				3. 19. 70 - 2.55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospital</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 4940, EASTERN AVENUE Balt Md 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2612</b>			
5. SEX <b>Female</b> 6. RACE <b>Negro</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-6-95</b> 9. AGE (In years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>JAMES</b>				14. MOTHER'S MAIDEN NAME <b>GUSSIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>BCH*Records</b> ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Probable Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Spartic Quadriplegia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Reserve Lt B. B. B.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>4 years</b> <b>8 years</b>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1st 1970</b> to <b>3. 19. 1970</b> that (I) <del>(we)</del> lost saw the deceased alive on <b>3. 19. 1970</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>R. Venkatesan</b>				23B. DATE SIGNED <b>3. 19. 70</b>		23C. PHYSICIAN'S NAME (Type) <b>R. VENKATESAN, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>P. J. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>John C. J. J. J.</b>		ADDRESS <b>11297 Caroline St.</b>	

1. 1941-1942

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3. 1945-1946

4. 1947-1948

5. 1949-1950

6. 1951-1952

7. 1953-1954

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9. 1955-1956

10. 1957-1958

11. 1959-1960

12. 1961-1962

13. 1963-1964

14. 1965-1966

15. 1967-1968

16. 1969-1970

17. 1971-1972

18. 1973-1974

19. 1975-1976

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21. 1979-1980

22. 1981-1982

23. 1983-1984

24. 1985-1986

25. 1987-1988

26. 1989-1990

27. 1991-1992

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30. 1997-1998

31. 1999-2000

32. 2001-2002

33. 2003-2004

34. 2005-2006

35. 2007-2008

36. 2009-2010

37. 2011-2012

38. 2013-2014

39. 2015-2016

40. 2017-2018

41. 2019-2020

42. 2021-2022

43. 2023-2024

44. 2025-2026

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82. 2101-2102

83. 2103-2104

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85. 2107-2108

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S-361

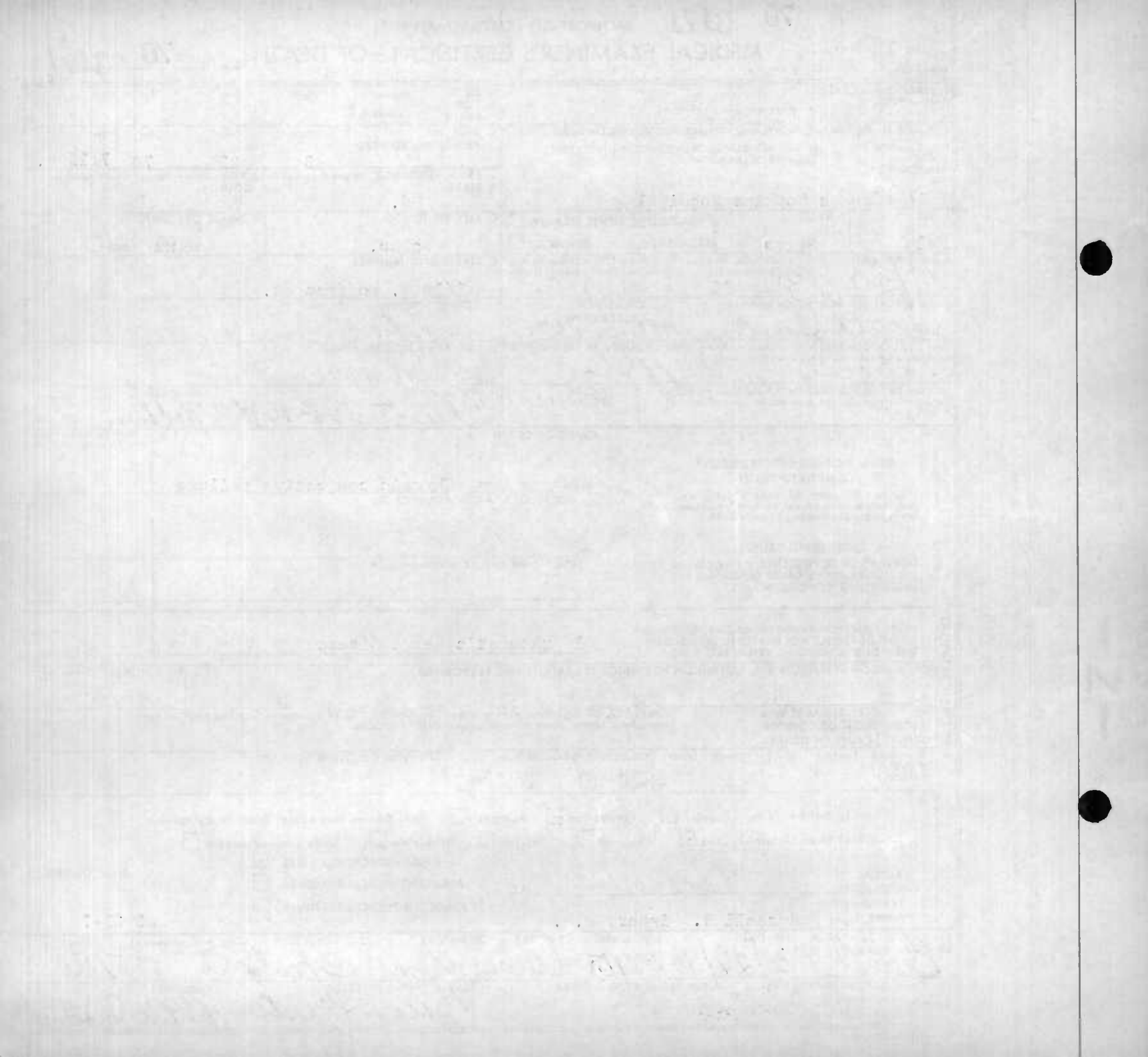
70 3171

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3171

1. NAME OF DECEASED (Type or Print) <b>PRESIDENT STRAFORD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 23 70 7:15 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7/22/13</b>		10. AGE (in years last birthday) <b>56</b>	
11. BIRTH PLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Smith &amp; Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Lila Straford</b>		ADDRESS <b>1618 E. Hoffman St.</b>	
19. <b>427.01</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Chronic congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <b>Russell S. Fisher, M.D.</b>		DATE SIGNED <b>3-23-70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/26/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Stearns, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Grace E. Clicker</b>		ADDRESS <b>1129 N. Caroline St.</b>	



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D-242 70 3172

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3172

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD DOUGLAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 11:05 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8-1-1906</b>		10. AGE (In years lost birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Tyaskins, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Douglas</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>805</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Handy</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>215-05-0447</b>		18. INFORMANT <b>Mrs. Bertha Sledge</b>	
19. ADDRESS <b>2118 N. Wolfe Street</b>		20. ADDRESS <b>2118 N. Wolfe Street</b>	

19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **3/22/70**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-27-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Freeman Chapel Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Tyaskins, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	





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7-652 70 3173

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3173

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES TORRENCE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3406 Bateman St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 22 70 4:05 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1538</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-22-1896</b>		10. AGE (in years lost birthday) <b>73</b>	
11. BIRTHPLACE (State or foreign country) <b>Southern Pines, N.C.</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Torrence</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
15. MOTHER'S MAIDEN NAME <b>Sara Torrence</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>217-07-8074</b>		18. INFORMANT ADDRESS <b>Mrs. Theresa Claiborne 716 Peach Orchard La.</b>	
19. <b>412.41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3-23-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-26-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3174</span>	
BIRTH NO. <span style="float: right;">70 3174</span>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
BROCKINGTON Victoria V.			3-23-70 6 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			USA MARYLAND 2716		
SINAI Hospital 421			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4705 Park Heights AVE #3					
5. SEX F	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-23	9. AGE (In years last birthday) 46	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jessie Jefferson			14. MOTHER'S MAIDEN NAME Angerone Jefferson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. (INFORMANT) ADDRESS Mrs Douglas Brockington Same
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Hypertensive Crisis Cardiovascular (C) Accident		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 21 19 70 to March 23 19 70 that (I) (we) last saw the deceased alive on 2-22 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Zita Yorro			23B. DATE SIGNED 3-23-70		23C. PHYSICIAN'S NAME (Type) ZITA B. YORRO MD
23D. ADDRESS Morton Dyett F.H. 1701 Laurens St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/26/70		24C. NAME OF CEMETERY OR CREMATORY Balt. Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR ADDRESS	

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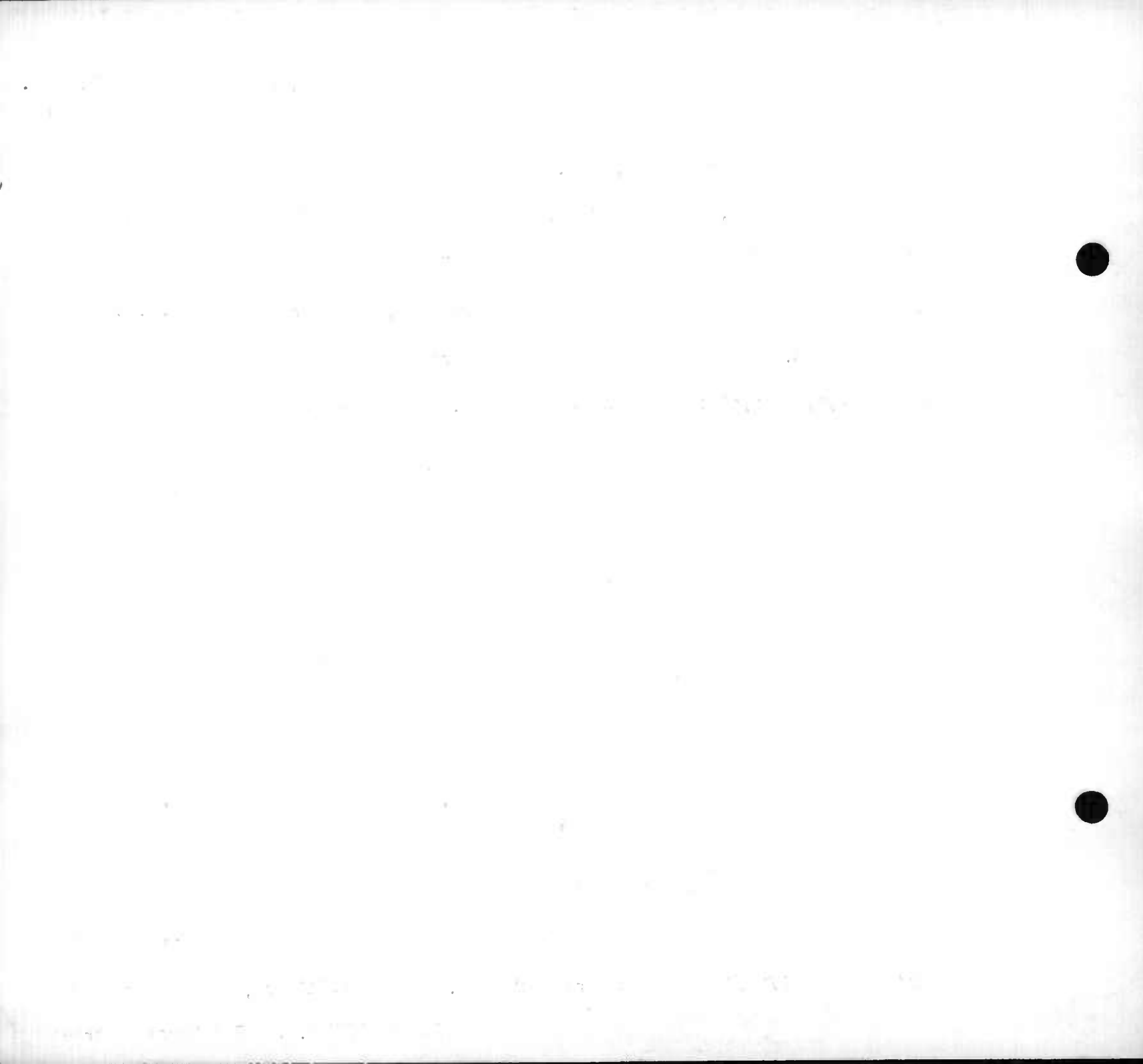
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3175</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">70 3175</span>		1. NAME OF DECEASED (Type or Print) <span style="float: right;">William Ray</span>		2. DATE AND HOUR OF DEATH March 23, 1970 <span style="float: right;">1:30 p.m.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 2em;">39</span> Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">1502</span>		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1678 Bruce Court		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-86	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unk.			14. MOTHER'S MAIDEN NAME Martha Ray		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/3/18 3/28/1919		16. SOCIAL SECURITY NO. 218-07-0178A	17. INFORMANT Mrs. Mary Ray- wife		ADDRESS SAME
18. <span style="font-size: 1.5em;">410.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Myocardial Infarction</span> (B) <span style="font-size: 1.5em;">ASCVD</span> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 19,</u> 19 <u>79</u> to <u>March 23,</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>March 23,</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">G. Tengoco MD</span>			23B. DATE SIGNED 3-23-70		23C. PHYSICIAN'S NAME (Type) G. TENGOCO MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3/26/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.
24D. LOCATION Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.			25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		
25D. ADDRESS 1701 Laurens Street					



M-420

70 3176

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3176

1. NAME OF DECEASED (Type or Print) <b>RUBIN MILES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 20, 1970</b> Hour <b>10:30 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept. 1, 1935</b>		10. AGE (In years last birthday) <b>34</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Miles</b>		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b>	
15. MOTHER'S MAIDEN NAME <b>Frances Carver</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Alane Council 2437 E. Hoffman St. 21213</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>E9651X</b>		CAUSE OF DEATH <b>Gunshot wound of chest</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. (C) _____		23. _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hideaway Bar</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1701 Ellsworth Street 807</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>3-20-70 10:00 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3/21/70</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>3-27-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213 Marshall W. Jones, Jr.</b>	

N 87511

RECEIVED IN A BOLD

DATE 20/11/01

VALUE 1000000

NO 1000000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3177</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">70 3177</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <span style="font-size: 1.2em;">ERHART</span> <span style="font-size: 1.2em;">Earhardt, Joseph Vincent</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/20/70</span>   <span style="font-size: 1.2em;">2:45 A.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>		<b>4. USUAL RESIDENCE</b> <small>(Where deceased lived, if institution; residence before admission)</small> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>A. STATE</b>  <span style="font-size: 1.2em;">Maryland</span> </div> <div style="width: 40%;"> <b>B. COUNTY</b>  <span style="font-size: 1.2em;">21224/03</span> </div> </div>			
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> <small>(Give kind of work done during most of working life, even if retired)</small>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Sunther's Brewery</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">8-29-97</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Earhardt, Benjamin</span>		<b>11. BIRTHPLACE</b> <small>(State or foreign country)</small> <span style="font-size: 1.2em;">Maryland</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">NCGH chart.</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">METASTATIC CARCINOMA</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">3/19/70</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Nodular Nodule on chest wall</span>		<b>20A. AUTOPSY?</b> <small>(Yes or No)</small> <span style="font-size: 1.2em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <small>(notify medical examiner)</small>		<b>21B. PLACE OF INJURY</b> <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		<b>21C. WHERE DID INJURY OCCUR?</b> <small>(If in Baltimore City, give exact location)</small>	
<b>21D. TIME OF INJURY</b> <small>(Month) (Day) (Year) (Hour)</small> <b>(APPROX.)</b>		<b>21E. INJURY OCCURRED</b> <div style="display: flex; justify-content: space-between;"> <div>While At Work <input type="checkbox"/></div> <div>Not While At Work <input type="checkbox"/></div> </div>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-13 19 70</span> to <span style="font-size: 1.2em;">3-20 19 70</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-20 19 70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Danilo V. Santos M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/20/70</span>	
<b>23C. PHYSICIAN'S NAME</b> <small>(Type)</small> <span style="font-size: 1.2em;">DANILLO V. SANTOS M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">North Charles Gen. Hosp.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> <small>(Specify)</small> <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/23/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">HOLY REDEEMER CEM.</span>	
<b>24D. LOCATION</b> <small>(City, town, or county) (State)</small> <span style="font-size: 1.2em;">BALTIMORE MD.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 25 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">E. E. E. E.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">RAYMOND H. KACZOROWSKI</span>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM REDDICKS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1428 Druid Hill Avenue (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 21, 1970 10:35 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8/4/28</b>	10. AGE (In years lost birthday) <b>45</b>	E. STREET AND NUMBER <b>1428 Druid Hill Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W W 2</b>		17. SOCIAL SECURITY NO. <b>224-20-8285</b>	
18. INFORMANT <b>Mr Charles Price, 507 Radnor Ave</b>		ADDRESS	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/22/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/26/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

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SCHOOL SUPERINTENDENTS  
OF THE STATE OF TEXAS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HATTIE WASHINGTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1834 Brunt St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 23 70 4:40 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7/31/94</b>		10. AGE (In years) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. <b>7 10 7 6</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Young</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1403</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Rebecca</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr Alexander Young, 809 McKean Ave</b>	
19. CAUSE OF DEATH <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED <b>3-24-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/27/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 25 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W north A</b>	

7

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U.S.A. 44-38861-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		70 3180	
W-400		70 3180		70 3180		70 3180		70 3180	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Irene C. Wiley</u>		2. DATE AND HOUR OF DEATH <u>17 Mar 1970 1155 P</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>ESSEX</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4 Goeller Ave</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-13-25</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Behme</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Hospital Chart</u>	
18. <u>412.4 I</u>		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) DUE TO, OR AS A CONSEQUENCE OF:							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>3-15</u> 19 <u>70</u> to <u>3-17</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>3-17</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		23A. SIGNATURE <u>M. Condo M.D.</u>		23B. DATE SIGNED <u>17 Mar 70</u>					
23C. PHYSICIAN'S NAME (Type) <u>M. Condo</u>		23D. ADDRESS <u>Union Memorial Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/20/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 25 1970</u>		25B. NAME OF REGISTRAR <u>Paul E. Tubing M.D.</u>		25C. FUNERAL DIRECTOR <u>J. G. GORRELL &amp; SONS</u>		ADDRESS <u>300 MAIZE</u>			

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BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3181			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) MARGARET ANNE BAKER						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 18, 1970 5:30 P.M.			3. DATE OF DEATH Month Day Year March 18, 1970 5:30 P.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital						5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300					
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN ESSEX			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
9. DATE OF BIRTH 6/13/10		10. AGE (In years lost birthday) 58		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? USA			13. STREET AND NUMBER 917 Lutz Avenue		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1				14B. KIND OF BUSINESS OR INDUSTRY MARTIN'S				15. FATHER'S NAME WM. McELROY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK				17. SOCIAL SECURITY NO. 214-20-25X		18. INFORMANT MRS. FRANK CLARKE			ADDRESS 1110 TACE		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 0											
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
21. AUTOPSY? (Yes or No) No											
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eastern Boulevard - Essex (Balt. Co.)			
22D. TIME OF INJURY (APPROX.) 3-18-70 4:45 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Pedestrian hit by car after car involved in auto-auto collision			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED March 19, 1970			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/23/70		24C. NAME OF CEMETERY or CREMATORY SACRED HEART				24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. MAR 25 1970				25B. NAME OF REGISTRAR Robert E. Bailey, M.D.				25C. FUNERAL DIRECTOR ADDRESS J.G. CONNELLY SONS 300 MACE			



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

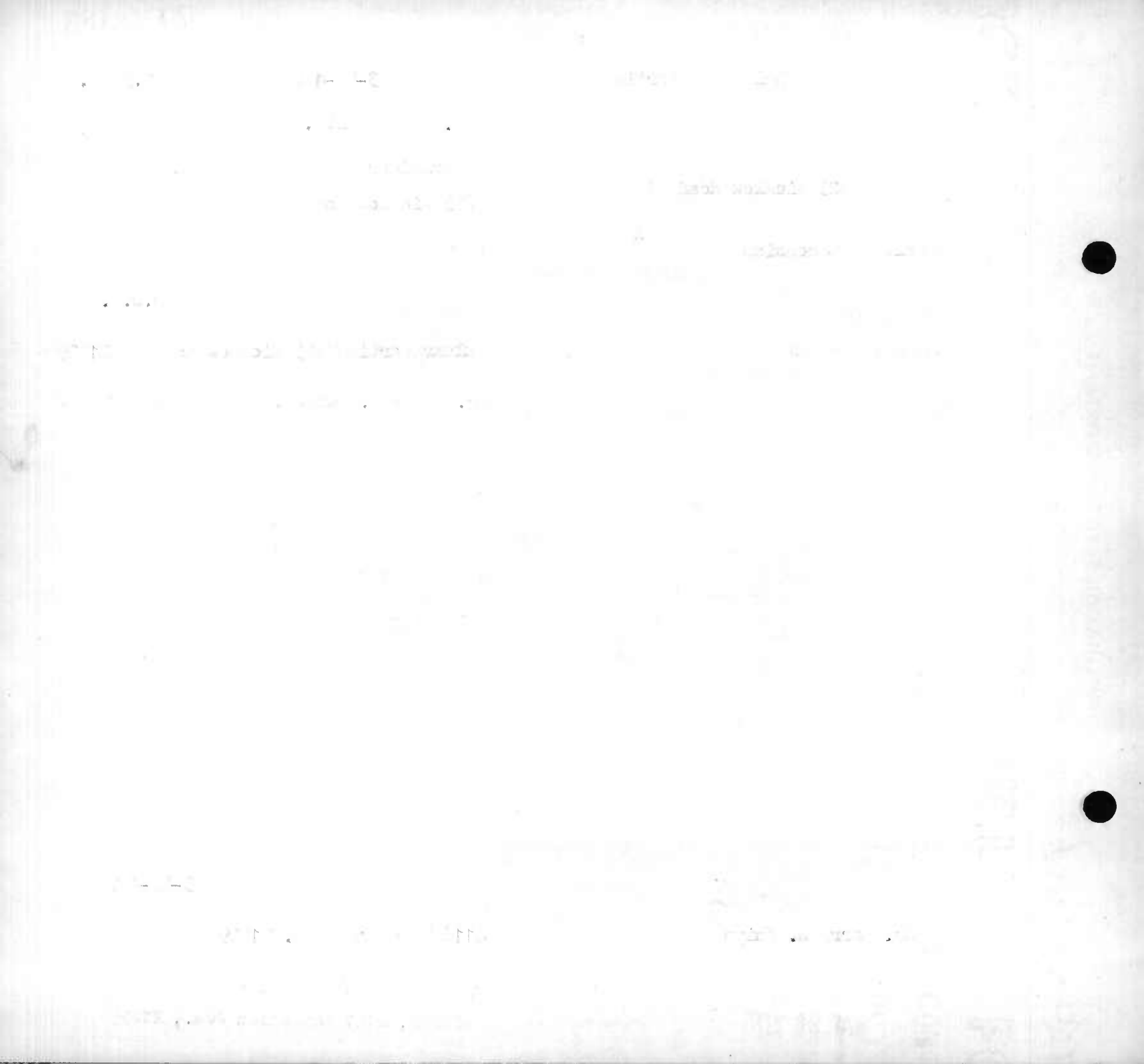
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 3182</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Schlegel, Margaret D.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">March 25th, 1970</span>   <span style="font-size: 1.2em;">11:55</span> AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2834</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">40</span> Saint Agnes Hospital Caton & Wilkens Aves. 21229		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">General German Aged Peoples Home</span>		22 South Athol Ave 29	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">Cau</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1/15/85</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">85</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">General German Aged Home, 22 s. Athol Ave.</span>	
18. <span style="font-size: 1.5em;">412.21</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CUA</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">A. SCVD.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">75 hours</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <span style="font-size: 1.2em;">Hypertension</span>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) <span style="font-size: 1.2em;">years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 25</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">March 25</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 25</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Alejandro Mejia</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Alejandro Mejia MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">St Agnes Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">3/28/70</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 26 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Witzke, 4101 Edmondson Ave., 21229</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

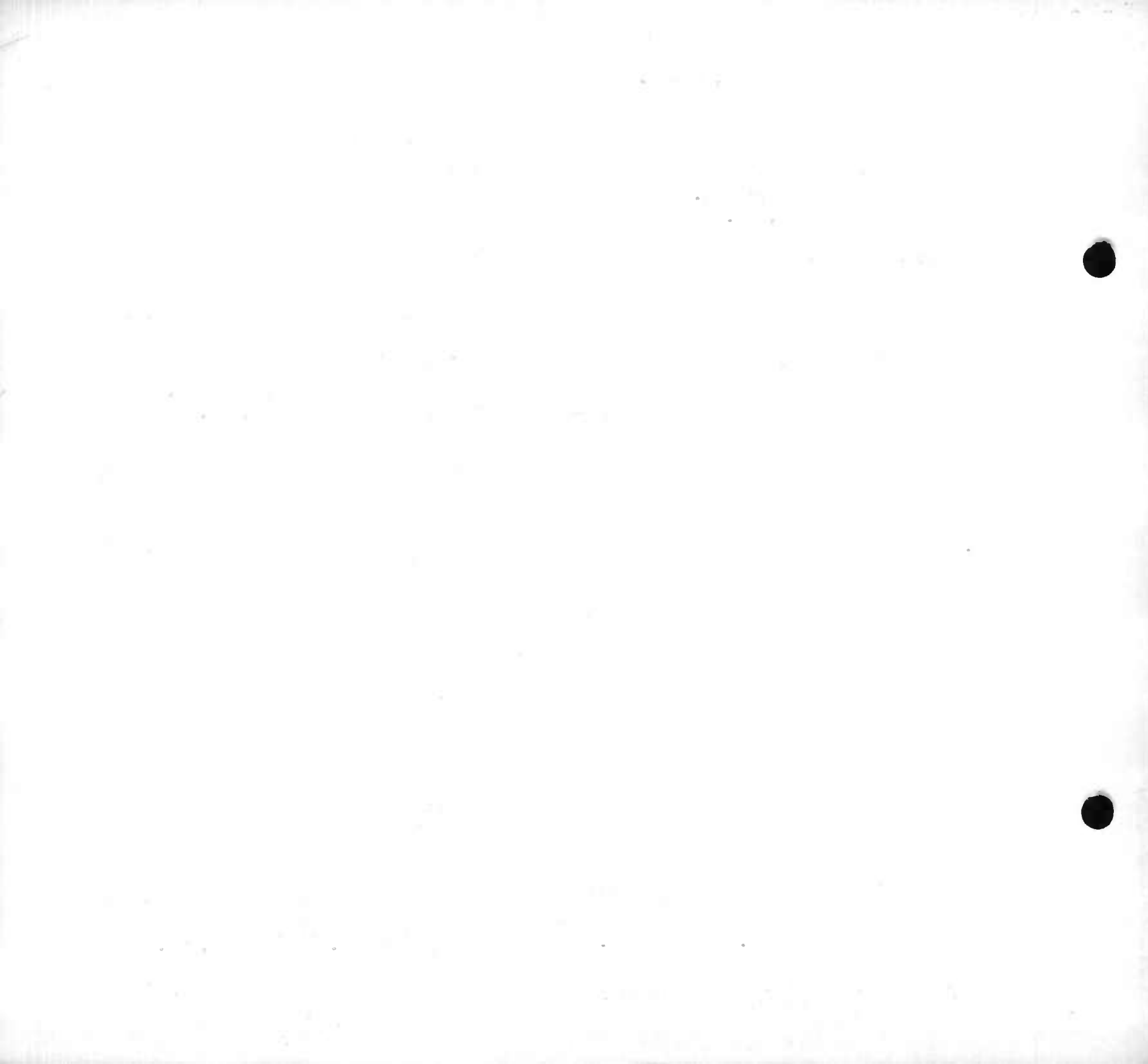
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3183</span>	
BIRTH NO. <span style="float: right;">70 3183</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Lula Martin</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">3-25-1970 2.30 A. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 2em;">00</span> 823 Wicklow Road		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">Balto.</span> <span style="font-size: 2em; float: right;">2844</span>			
		C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="float: right;">823 Wicklow Road</span>			
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">Caucasian</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <span style="float: right;">10/1/89</span>	9. AGE (In years lost birthday) <span style="float: right;">80</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Maryland</span>	
13. FATHER'S NAME <span style="float: right;">Joseph Burrows</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Florence</span> <del>Elmer Martin 823 Wicklow Road 21229</del>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="float: right;">Mr. Elmer H. Martin, 823 Wicklow Road 21229</span>	
18. <span style="font-size: 2em;">44121</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Ruptured abdominal aortic aneurysm</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.5em;">Atherosclerotic Cardio Vascular disease</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.5em;">Benign Hypertension</span>  <span style="font-size: 1.5em;">Hypertension</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">sudden</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <span style="font-size: 1.5em;">1-19-1965</span> to <span style="font-size: 1.5em;">3-25-1970</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.5em;">3-25-1970</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Harry L. Knipp, M.D.</span>				23B. DATE SIGNED <span style="float: right;">3-25-1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">Dr. Harry L. Knipp</span>				23D. ADDRESS <span style="float: right;">4116 Edmondson Ave., 21229</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">3/28/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Loudon Park Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 26 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="float: right;">Witzke, 4101 Edmondson Ave., 21229</span>	



# FUNERAL DIRECTOR: IMPORTANT

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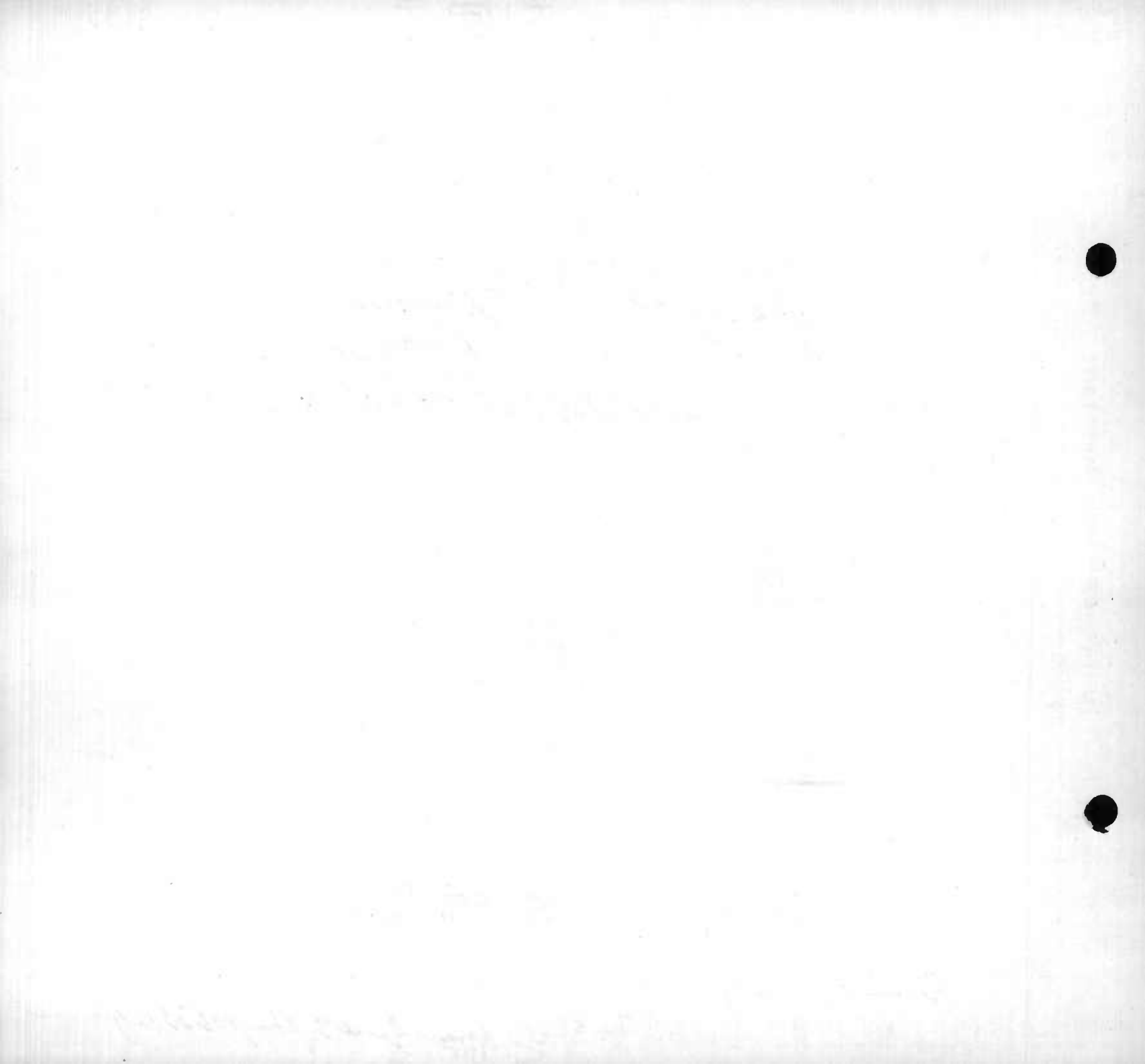
32-03-75 JD		70 3184		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3184	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
				Holloway, Emma T.				3-24-70 1 500 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE				B. COUNTY	
Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				South Carolina				V-37	
5. SEX				6. RACE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female				Negro				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH	
								7-21-24	
11. BIRTHPLACE (State or foreign country)				9. AGE (in years last birthday)				If Under 1 Yr. Months Days	
South Carolina				45				If Under 24 Hrs. Hours Min.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
U.S.A.				Beachman				Cordie NICHOLS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT	
no				289-34-64-27				4940 Eastern Ave. ADDRESS	
								BCH Records: Baltimore, Md. 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				4 days	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Bacterial sepsis					
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				2 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Sepsy syndrome					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Generalized herpes infection					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
								yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
								Yes	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from				Feb 10 1970 to Mar 24 1970					
that (I) (we) last saw the deceased alive on				Mar 24 1970 and that (in) (my) (our) applan death occurred on the date					
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
James T. Corkins MD				3-24-70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
James T. Corkins Md.				Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224					
24A. BURIAL CREMATION, REMOVAL, (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY	
Removal				3/26/70				Family Plot	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR	
MAR 26 1970				R. E. Fabel, Jr.				Marshall R. Hyatt 3800 Johns St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3185</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Rufus Stokes</b>		2. DATE AND HOUR OF DEATH <b>3-24-70 16 45</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1604</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>703 Appleton Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-30</b>	9. AGE (In years lost birthday) <b>69 70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FURMAN N.C.</b>	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA STUBACOS FIELD</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-9716</b>		17. INFORMANT <b>HELEN STOKES 703 APPLETON ST</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA LEFT LUNG</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA LEFT LUNG</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-5-1970</b> to <b>3-24-1970</b> , that (I) (we) last saw the deceased alive on <b>3-24-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul M. B. B.S.</b>		23B. DATE SIGNED <b>3-24-1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>PREM LAL, M.B.; B.S.</b>		23D. ADDRESS <b>730 ASHBURTON STREET BALTIMORE, MD. 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/25/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>WINDYBROOK</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Marjorie D. Bayne, M.B.; B.S.</b>	
				ADDRESS	



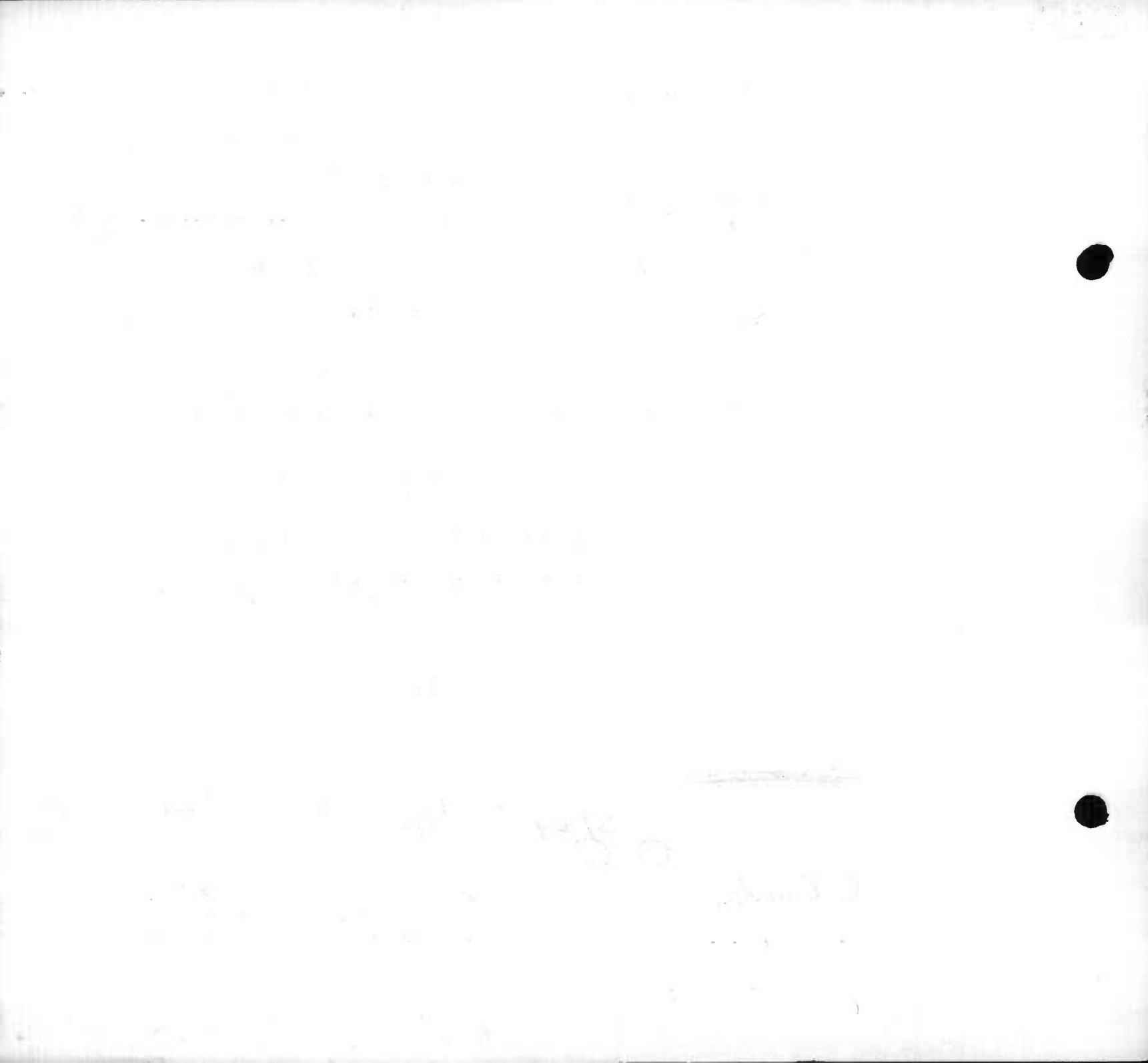


54-07-48 is

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-352		70 3186		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3186	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ann Stankus (ONAB. STANKUS)				2. DATE AND HOUR OF DEATH 3-24-70		3:40 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. CO. 21222 C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 230 Cleveland Ave., Baltimore, Md. 21224			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1898	9. AGE (In years last birthday) 71	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lithuania		
13. FATHER'S NAME Joseph			14. MOTHER'S MAIDEN NAME -UNK-				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-0833		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) metastatic carcinoma of DUE TO, OR AS A CONSEQUENCE OF: (C) breast & Right hemiparesis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 4-24-70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/24 1969 to 3/24 1970 that (I) (we) last saw the deceased alive on 3/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Krush				23B. DATE SIGNED 3/24/70		23C. PHYSICIAN'S NAME (Type) C. Krush, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 3-28-70		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) BALTIMORE, Md.				24E. NAME OF REGISTRAR W. P. Smith, M.D.			
25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970				25B. FUNERAL DIRECTOR W. P. Smith, M.D.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>ROBERT B MUNNIKHUYSEN</b>		2. DATE AND HOUR OF DEATH <b>Mar 24 1970 8:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>90 EDGEWOOD NURSING HOME</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 EDGEWOOD NURSING HOME</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4406 Fernhill Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/19</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. &amp; G Asst Treasurer</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Munnikhuyesen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-05-6743</b>	
17. INFORMANT <b>Lutine K. Munnikhuyesen - 4406 Fernhill Ave</b>		ADDRESS	
18. <b>412.4 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>112yr</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-20 1964</b> to <b>3-24 1970</b> that (I) (we) last saw the deceased alive on <b>3-18 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Frederick J. Vollmer MD</b>		23B. DATE SIGNED <b>3-24-70</b>	
23C. PHYSICIAN'S NAME (Typal) <b>FREDERICK J VOLLMER MD</b>		23D. ADDRESS <b>6100 YORK RD BALTIMORE MD 21212</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-26-70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Rock Spring Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Forest Hill, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Armacost Funeral Chapel-4600 Liberty Hts.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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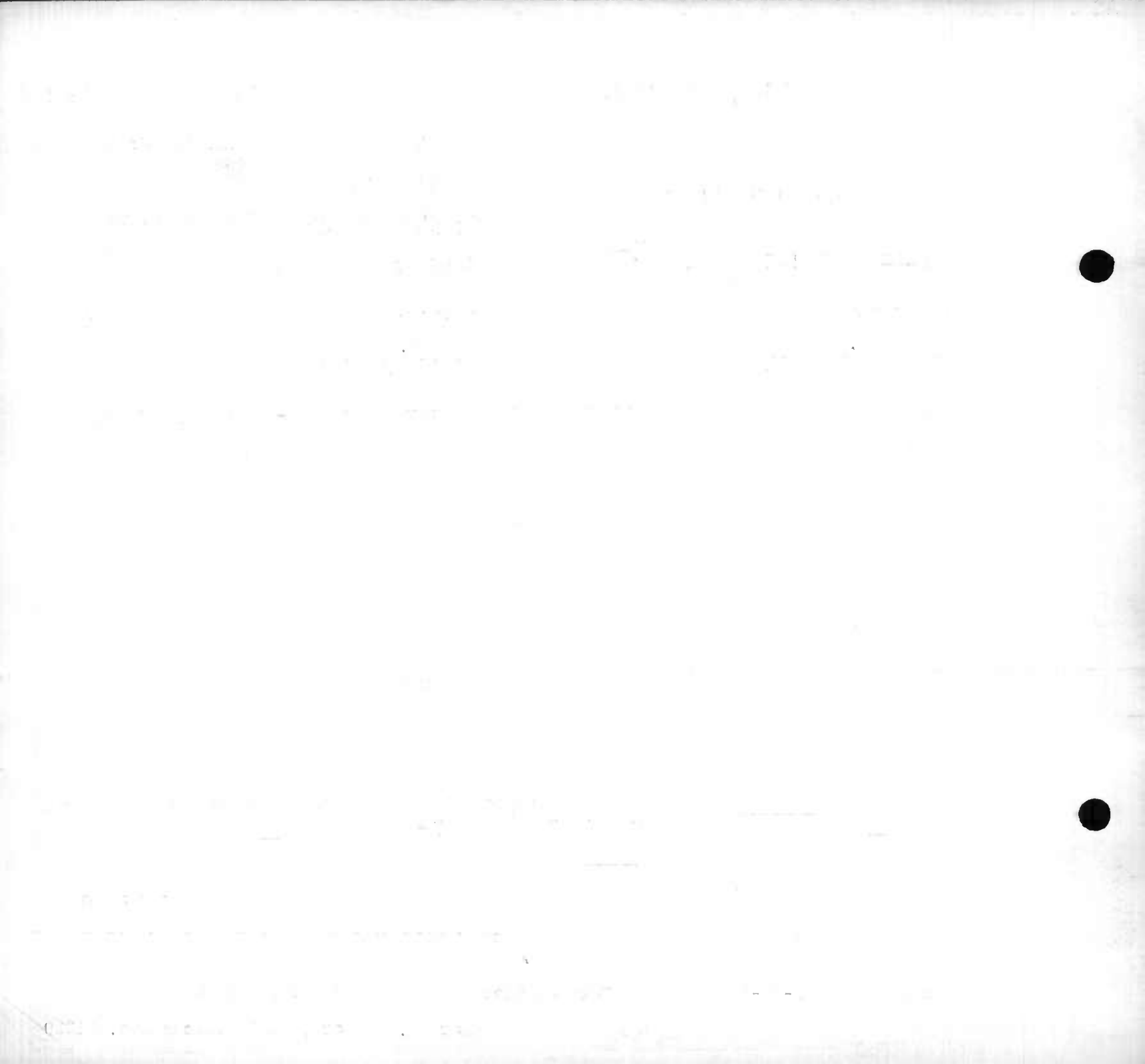
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3188</u>	
X-520-70 3188				BIRTH NO. <u>Cecil W. Md.</u>	
1. NAME OF DECEASED (Type or Print) <b>MARIE CATHERINE KING</b>				2. DATE AND HOUR OF DEATH <b>MARCH 8, 1970 4:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>CECIL</b> C. CITY OR TOWN <b>ELKTON</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>R.D. #5 BOX 155</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 7, '70</b>		9. AGE (In years last birthday) <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>DAVID H. KING</b>			14. MOTHER'S MAIDEN NAME <b>EDITH OLIVER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. Lee Neidengard</b>
18. <b>772.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRAL DAMAGE</b> <b>BIRTH TRAUMA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>24 hrs</b> <b>24-36 hr</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examiner <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 7 1970</b> to <b>MARCH 8 1970</b> that (I) (we) last saw the deceased alive on <b>MARCH 8 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) view the body after death.					
23A. SIGNATURE <i>Lee Neidengard</i>				23B. DATE SIGNED <b>MARCH 8, '70</b>	
23C. PHYSICIAN'S NAME (Type) <b>LEE NEIDENGARD MD</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 11, '70</b>		24C. NAME of CEMETERY or CREMATORY <b>Cherry Hill Methodist Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Cherry Hill, Cecil, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Hicks Home For Funerals, Elkton, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-500 70 3189		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3189	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) WINN, BETTIE MAE			
2. DATE AND HOUR OF DEATH MARCH 23, 1970 7:30 AM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN N. LINTHICUM E. STREET AND NUMBER 18 Eleanor Avenue		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. SEX FEMALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06 26 23		9. AGE (In years lost birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME HERBERT GOSNELL		14. MOTHER'S MAIDEN NAME BESSIE WARFIELD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 217 16 5607		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) CIRCULATORY FAILURE ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. RENAL INSUFFICIENCY POLYCYSTIC KIDNEY DISEASE CHRONIC HEPATIC INSUFFICIENCY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days SEVERAL MONTHS 46 years NOT ESTABLISHED			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 6, 1970 to MARCH 23, 1970 that (I) (we) last saw the deceased alive on MARCH 23, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Julio Freijanes M.D.</i>				23B. DATE SIGNED 03 23 70		23C. PHYSICIAN'S NAME (Type) JULIO FREIJANES M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 3190 4</b>
BIRTH NO. <b>70-00826</b>				
1. NAME OF DECEASED (Type or Print) <b>BABY BOY BRAXTON</b>		2. DATE AND HOUR OF DEATH <b>1-17-70 11 40 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Lutheran Hospital of Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>1403</b>		
5. SEX <b>M</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER <b>510 Baker St. 4615 PARK HEIGHTS AVE</b>		
10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>40 30hr old</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>William Garnett Johnson</b>		14. MOTHER'S MAIDEN NAME <b>BRAXTON JUANITA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT		ADDRESS		
18. <b>776.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Distress</b>		APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <b>40 hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>IMMATUREITY</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Prematurity</b> (B) <b>Subarachnoid Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Pulmonary Atelectasis</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> 19 <b>70</b> to <b>1-16</b> 19 <b>70</b> , that (I) (we) lost saw the deceased alive on <b>1-16-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>M. J. Kork M.D.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>MIN JA KOOK M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>3-12-70</b>		24B. DATE		
24C. NAME OF CEMETERY		24D. NAME OF CEMETERY		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelley</b>		

**UNIVERSITY MEDICAL SCHOOL**  
**MORTUARY SERVICE - BCHD**

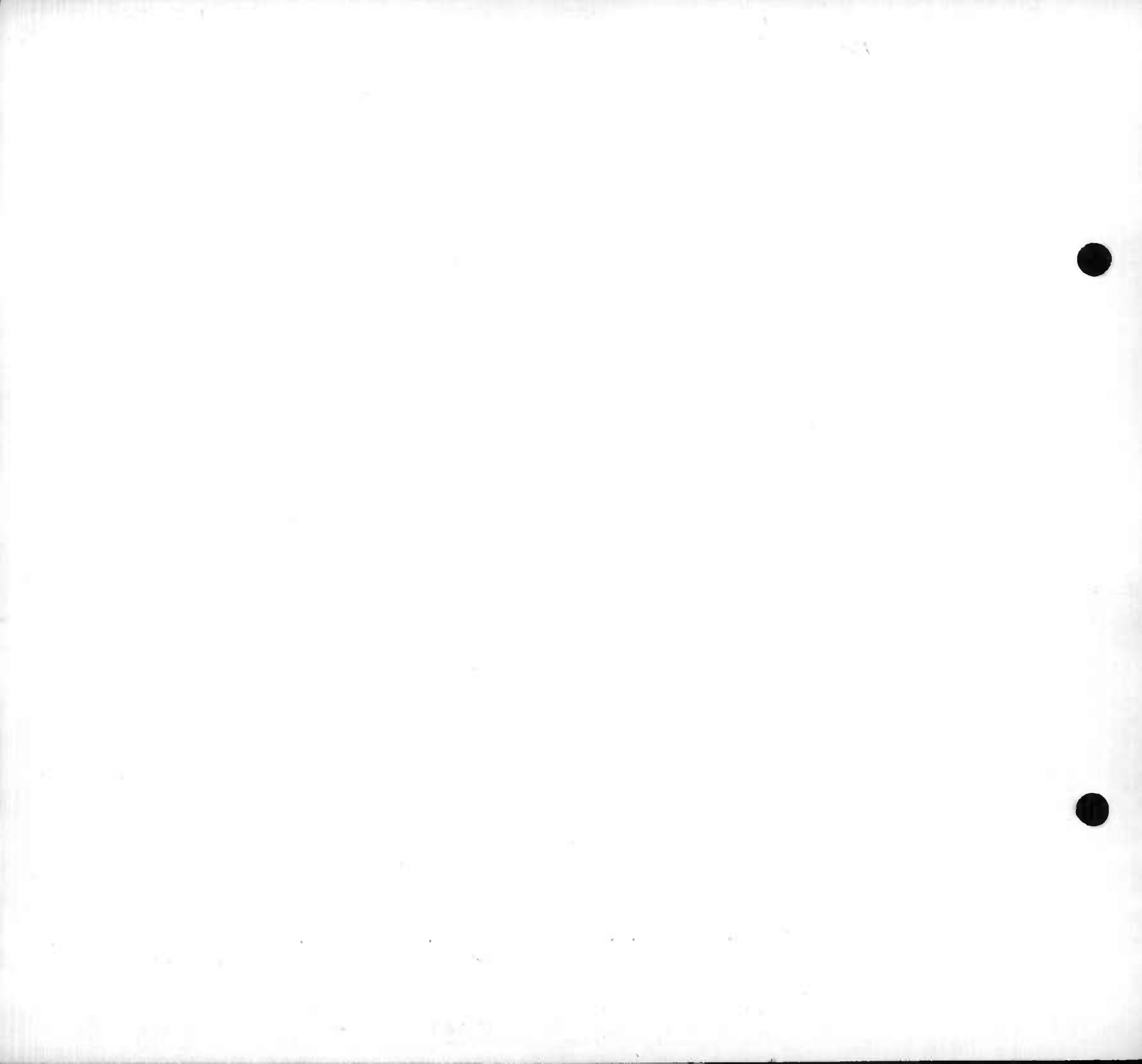
570 Baker st.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3191
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.
TAMELA SHRIE McCracken		3-5-70 10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
South Baltimore General Hospital 73		Md 2562		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
				3-2-70 3:15 PM
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		If Under 1 Yr. Months Days
Maryland		3 6 45		If Under 24 Hrs. Hours Min.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
US		Roy McCracken		
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Virginia Thomas		16. SOCIAL SECURITY NO.		
17. INFORMANT		ADDRESS		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Imaturity				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
1 Month 1 Day 1 Year 1 Hour		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from March 2 19 70 to March 5 19 70 that (I) (we) last saw the deceased alive on March 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Eleanor L. Noon M.D.				March 5, 1970
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
Eleanor L. Noon, M.D.				3001 S. Hanover St.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY
		3-12-70		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
MAR 26 1970		Robert E. Fisher, M.D.		

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3192</b> ✓	
M-213 70 3192		BIRTH NO. <b>76-03578</b>	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy McFadden</b>		2. DATE AND HOUR OF DEATH <b>2-26-70 4:05/A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>55 1824 Abington St #1</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3A 2-26-70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>10 min</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Valdaster McFadden</b>		14. MOTHER'S MAIDEN NAME <b>E. Laise WhiteHadsame</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother</b>		ADDRESS <b>same</b>	
18. <b>77 2X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>228 wks gestation</b> <b>Premiable</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2-26 3A 19 70</b> to <b>4A same date</b> that (I) (we) lost saw the deceased alive on <b>2-26 19 70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Polly Roberts MD</b>		23B. DATE SIGNED <b>2/26/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3-17-70</b>	
24C. NAME OF CEMETERY or CREMATION		24D. CITY, TOWN, OR LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fadden, M.D.</b>	
25C. MORTUARY SERVICE - <b>BCMD</b>		25D. ADDRESS	

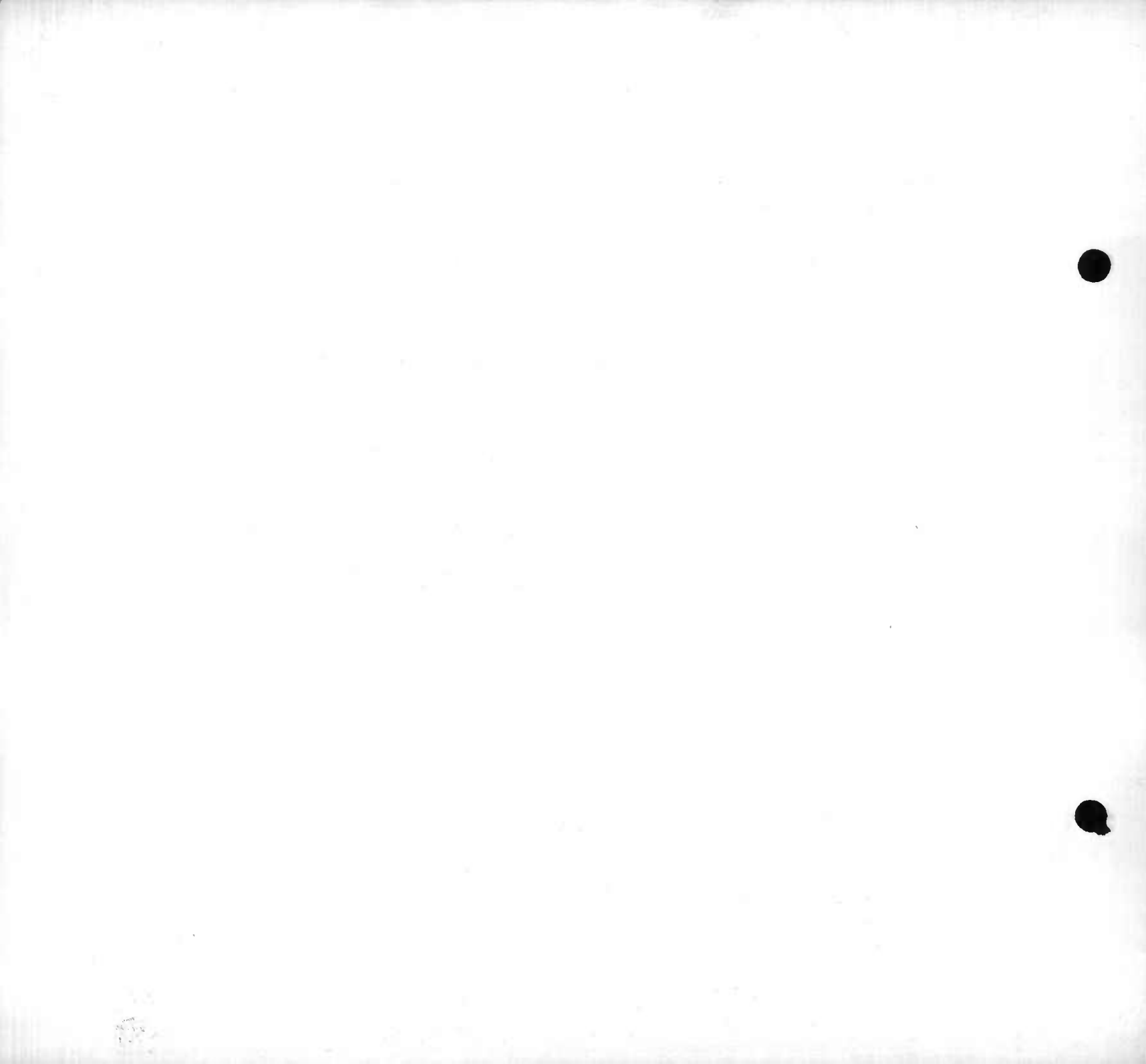
1824 Ashburton St 21216

Verified with Hospital. CT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
R-534 70 3193				70 3193	
BIRTH NO. 70-03317				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BABY BOY RUNDLE</b>			2. DATE AND HOUR OF DEATH <b>2-22-70 1:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			A. STATE <b>MD.</b> B. COUNTY <b>AA CO.</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE, MD.</b>			C. CITY OR TOWN <b>Green</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>204 Virginia Ave.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-70</b>	9. AGE (in years last birthday)	10. Under 1 Yr. Months Day Hours Min. <b>6 55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>CARL G RUNDLE</b>			14. MOTHER'S MAIDEN NAME <b>PEGGY RUNDLE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. <b>776.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIORESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY IMMATURITY</b> <b>PREMATURITY</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-21-70</b> 19 to <b>2-22</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>2-22</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Felix L. Kaufman M.D.</b>			23B. DATE SIGNED <b>2-22-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>FELIX L. KAUFMAN M.D.</b>			23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <b>3-17-70</b>		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		
25C. FUNERAL DIRECTOR			ADDRESS		
<b>MORTUARY SERVICE - BCHO</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3194</span> <span style="font-size: 1.5em;">4</span>	
S-152 70 3194		BIRTH NO. <span style="font-size: 1.2em;">70-03913</span>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Baby Boy Spencer</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-3-70</span> <span style="font-size: 1.2em;">6 58 PM.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">University Hospital</span>			A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">1802</span>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<span style="font-size: 1.2em;">38</span>			E. STREET AND NUMBER <span style="font-size: 1.2em;">1052 W. Fayette St. 21223</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/3/70</span>	9. AGE in years (at birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Infant</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>		
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">JAMES STEWART</span>			14. MOTHER'S M maiden NAME <span style="font-size: 1.2em;">Costella SPENCER</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">N/A</span>		
17. INFORMANT ADDRESS <span style="font-size: 1.2em;">patient chart # 39-55-05-</span>					
18. <span style="font-size: 1.2em;">777X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Prematurity</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">~ 28-30 wk gestat.</span>  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">48 min.</span>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-3-</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3-3-</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-3-</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Tolly Roberts, MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">3-3-70</span>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <span style="font-size: 1.2em;">3-17-70</span>		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
25C. FUNERAL DIRECTOR			25D. ADDRESS		

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



F-652

70 3195

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3195

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT FRANKENBERG</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>517 Cathedral Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>February 20, 1970</b> Hour <b>12:20 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH 10. AGE (In years last birthday) <b>63</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER <b>517 Cathedral Street</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. <b>412.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/21/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3-13-70</b>	
24C. NAME OF CEMETERY OR CREMATION		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

1745-1746

C-455

70 3196

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3196

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ROGER COLEMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTO. GENERAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD February 21, 1970		Month Day Year		Hour M. 8:00 A.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2201	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 45-50?		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Epilepsy		CAUSE OF DEATH Epilepsy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) Old Healed Craniocerebral Injuries DUE TO, OR AS A CONSEQUENCE OF:					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 500 Block South Hanover Street 2201			
22D. TIME OF INJURY (APPROX.) Unk.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unk.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. DATE SIGNED: 2/21/70							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-70		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	

3125

RECEIVED BY MAIL - DATE OF DEATH

VALLEY FARM CO.

ACQUAINTANCE - FOND

3-12-12

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 2 27 70		Hour 9:20 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION		3. DATE PRONOUNCED DEAD Month Day Year		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Hour	
D.O.A. 1501 N. Eutaw St. Apt. 2b		February 27, 1970 9:20a. M.		Maryland		1401	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 65		E. STREET AND NUMBER 1501 N. Eutaw St. Apt. 2B			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. 412.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-70		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		(State)	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		MORTUARY SERVICE - BCTD	



Coded to 1501 N. Eutaw PL.

*[Handwritten signature]*

3-13-10



P-614

70

3198

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3198

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EARLEY L. PRIBBLE

2. DATE  
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

2

26

70

8:00 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00

1600 Carbon Ave. D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

February 26, 1970 8:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2506

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1600 Carbon Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

E 904 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Exposure  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Acute and chronic alcoholism  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home (bus)

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1600 Carbon Ave.

2506

22D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
Last seen 2 25 70 5 p.m.22E. INJURY OCCURRED  
WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject, while intoxicated, fell asleep

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒under bus, in which he lived  
and that on this basis, death in my opinionresulted from: Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

3.13.70

24C. NAME OF CEMETERY

ANATOMY BOARD OF MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 26 1970

25B. NAME OF REGISTRAR

Isidore Mihalakis, M.D.

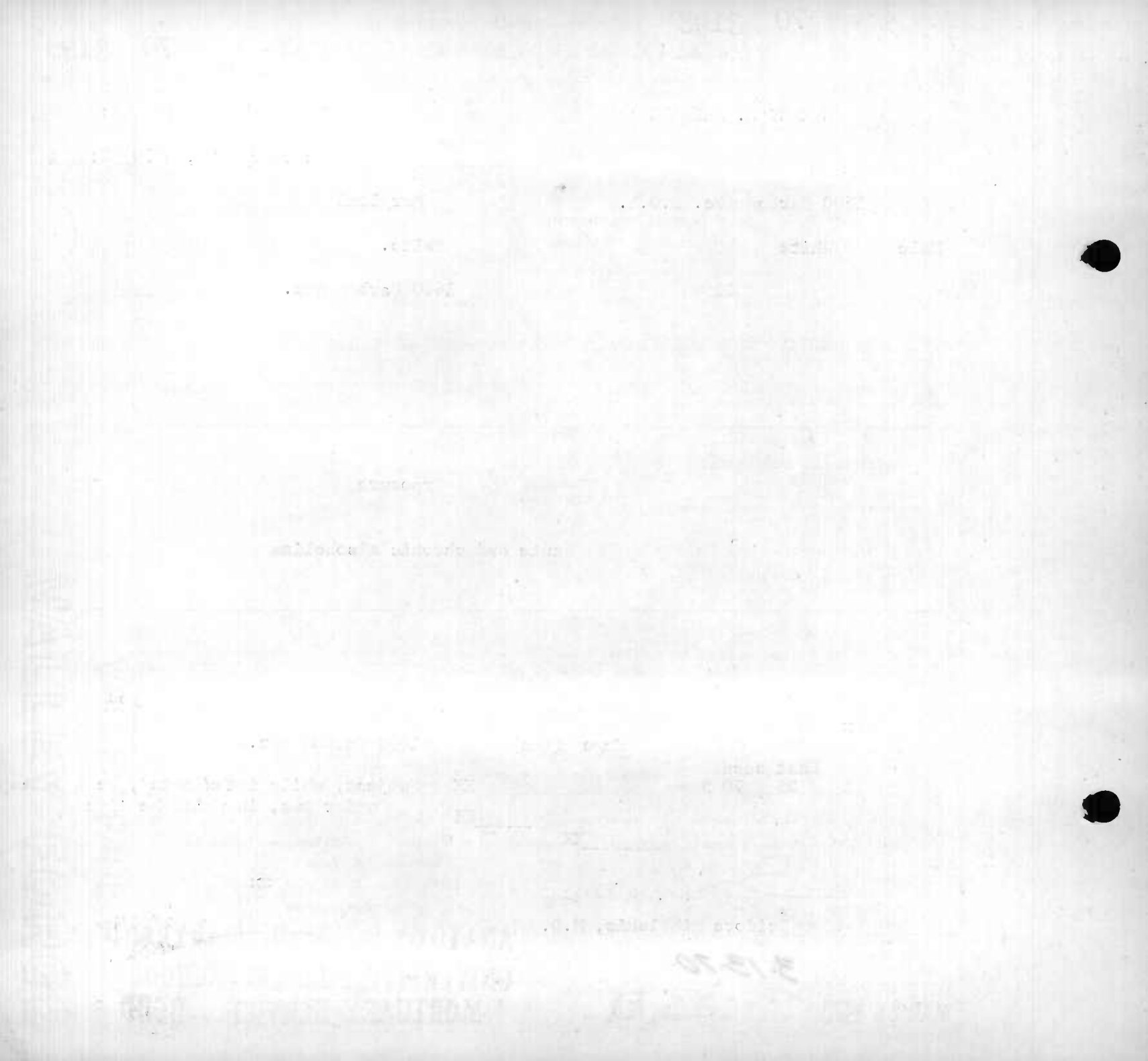
25C. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

N-9941F



BALTIMORE CITY HEALTH DEPARTMENT				70 3199			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>John CHARLES McLURKIN</u>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 337 W. Biddle Street</u>				3. DATE PRONOUNCED DEAD <u>March 21</u> , 1970 Year Hour <u>6:40 A.M.</u>			
6. SEX <u>Male</u>				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>			
7. RACE <u>Negro</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>1-14-21</u>		10. AGE (In years last birthday) <u>49?</u>		E. STREET AND NUMBER <u>337 W. Biddle Street</u>			
11. BIRTHPLACE (State or foreign country) <u>Chester S.C.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Andy McLURKIN</u>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>MARTHA EDWARDS</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>VE 10/30/42-5/22/43</u>		17. SOCIAL SECURITY NO. <u>249-16-9372</u>		18. INFORMANT ADDRESS <u>Wm. E. McLURKIN 3508 Mann St. E. Wash DC</u>			
19. <u>412.1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>NO</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/27/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louisa PK. NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>FREDERICK AVE. Balto. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph E. Locks</u>		ADDRESS <u>1304 N. Central Ave</u>	

ALCANTARA BOND

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3200

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NATHANIEL HAYS, JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>February 19, 1970</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>February 19, 1970 7:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2757</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN <b>Baltimore</b>
10. AGE (In years lost birthday) <b>62</b>		11. STREET AND NUMBER <b>7018 Marietta Avenue</b>	
12. BIRTHPLACE (State or foreign country)		13. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)

20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>	DATE SIGNED <b>February 19, 1970</b>
EXAMINER'S NAME (Type)	ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>3-13-70</b>	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State) <b>ANATOMY BOARD OF MARYLAND</b>
--	-----------------------------	------------------------------------	--

25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR (Address) <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>
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ACADEMY FOND

VALLEY LAMPS CO

1910

10-15-10



1

F-455 70 3201 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3201

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert F. Fleming		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1802 St. Paul St.		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				2	23	70	7:45 p. M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1205		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER		1802 St. Paul St.	
9. DATE OF BIRTH		10. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. 5-69-71		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gastro-intestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Fatty alteration of liver					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-70		24C. NAME OF CEMETERY		24D. LOCATION (If in Baltimore City, give exact location) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

DATE SIGNED 2/24/70

VS 151-REV. 1/1/68

ACADEMIC BOND

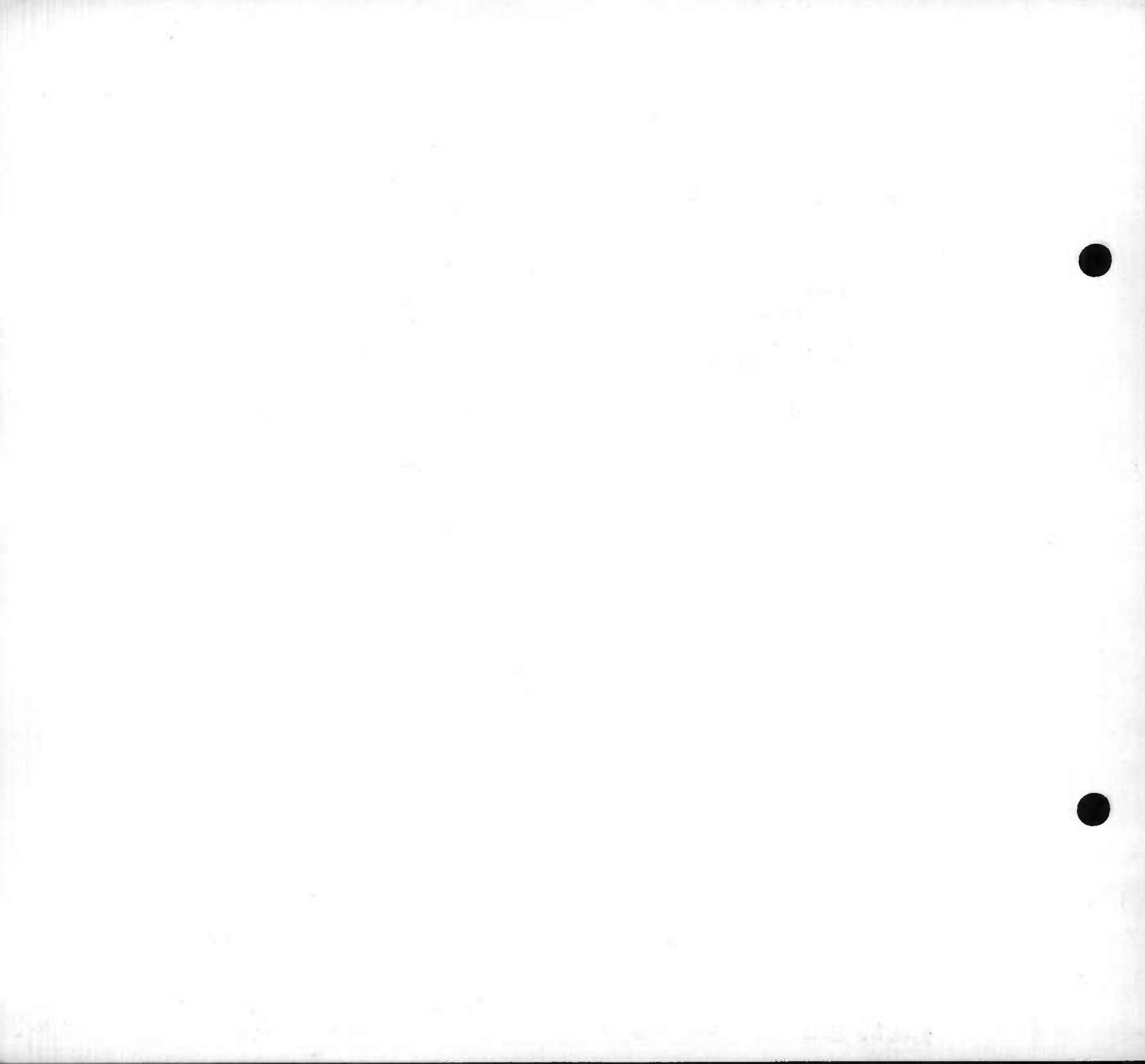
3-13-70



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

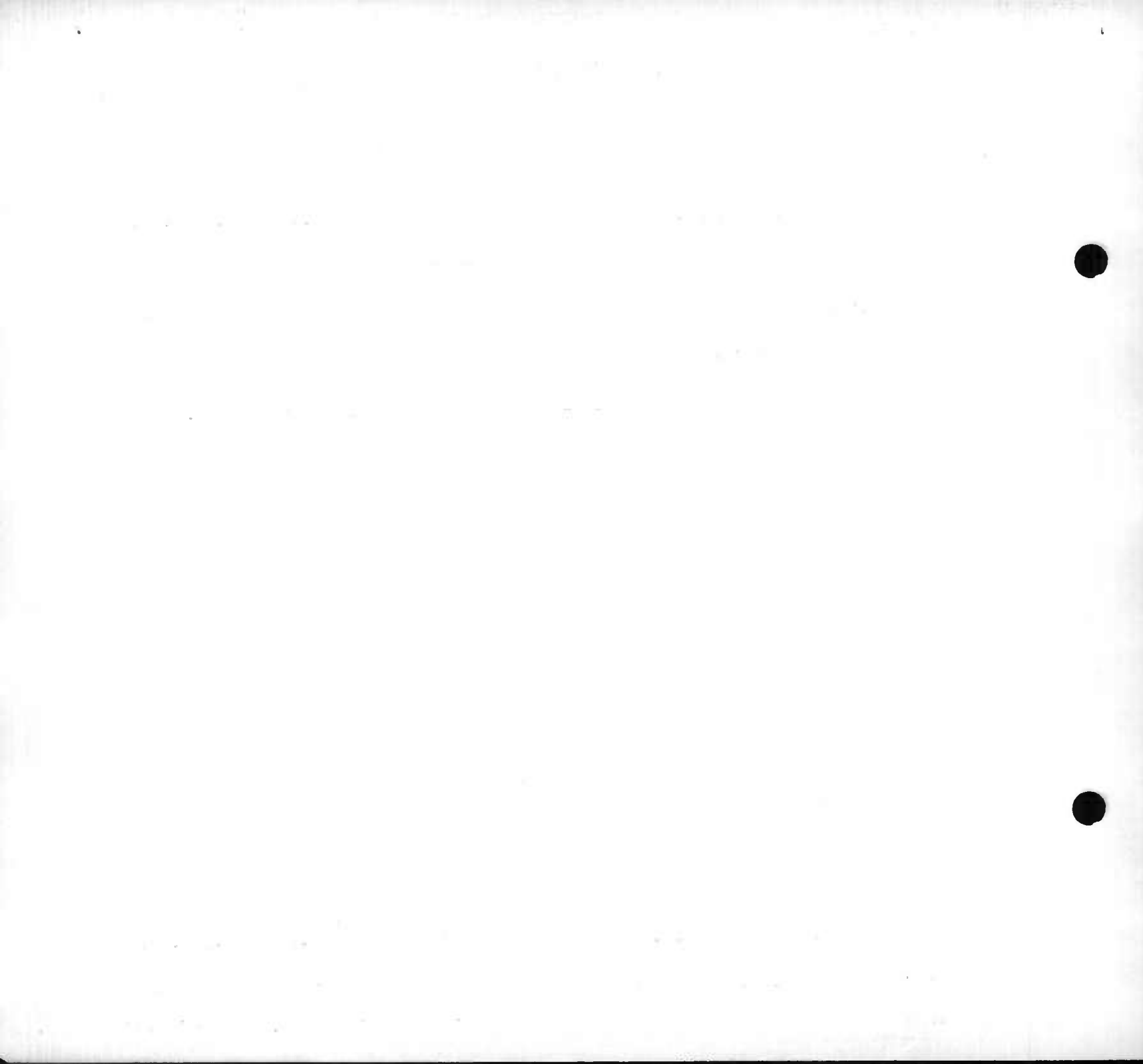
BALTIMORE CITY HEALTH DEPARTMENT				70 3202		REG. NO. 70 3202	
BIRTH NO. <u>L-000</u>		70 3202		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LEE, Mildred</u>				2. DATE AND HOUR OF DEATH <u>3/24/70</u> <u>2:00 a. m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>605</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1537 Mullikin Court</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/08</u>	9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Kelly</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Davis</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elmer Handy, 1500 Captain St.</u>		
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>2 wks</u> (B) <u>Carcinoma Cervix</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> <u>19</u> <u>70</u> to <u>3/23</u> <u>19</u> <u>70</u> that (I) (we) last saw the deceased alive on <u>3/24/</u> <u>19</u> <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert P. Prins</u>				23B. DATE SIGNED <u>3/24/70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Prins, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-28-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Whitman Cont</u>		24D. LOCATION (City, town, or county) (State) <u>Whitman Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.S.</u>		25C. FUNERAL DIRECTOR <u>Elmer O. Wilson</u>		ADDRESS <u>ref.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3203	
P-420 70 3203				REG. NO. 70 3203	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY E. PAWLOWICZ</b>		2. DATE AND HOUR OF DEATH <b>3/24/70 6:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>Baltimore City Hospital</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Md. 21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>103</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2427 Foster Ave., Balto., Md. 21224</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15-10</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Ernest Esterline</b>		14. MOTHER'S MAIDEN NAME <b>Helen McCord</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>162-44-1035</b>		17. INFORMANT <b>BCH Records: Baltimore, Md. 21224</b>	
18. <b>450X1425019</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLUS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIABETES MELLITUS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS.</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>3/24</b> 19 <b>70</b> to <b>3/24</b> 19 <b>70</b> that <del>the</del> (we) last saw the deceased alive on <b>3/24</b> 19 <b>70</b> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dennis W. Bleakley MD</b>			23B. DATE SIGNED <b>3/24/70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Dennis W. Bleakley, M.D.</b>			23D. ADDRESS <b>Baltimore City Hospital</b> <b>4940 Eastern Ave., Balto., Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-28-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>	
24D. LOCATION <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3204</span>	
<div style="display: flex; justify-content: space-between;"> <span>PL 400</span> <span>70 3204</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Benjamin T. Pool		March 24, 1970.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  44 99 Union Memorial Hospital-DOA		A. STATE Md. B. COUNTY 2758			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1631 Waverly Way			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1886	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Gas & Elec Co		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Pool		14. MOTHER'S MAIDEN NAME Mary Reynolds	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-6610 A		17. INFORMANT Mrs Emma Pool	
				ADDRESS Same	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Acute Congestive Failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Arteriosclerotic cardio-vascular disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  1 mo.  5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Obesity</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 8 - 1970</i> to <i>March 24</i> 1970, that (I) (we) last saw the deceased alive on <i>March 14</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. J. Sawyer Jr. M.D.</i>		23B. DATE SIGNED 3/25/70		23C. PHYSICIAN'S NAME (Type) G. J. SAWYER, JR.	
23D. ADDRESS 4808 Harford Rd. Balto Md.		23E. DEGREE DEGREE		23F. DEGREE DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/70		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAR 26 1970		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24H. ADDRESS		24I. ADDRESS	

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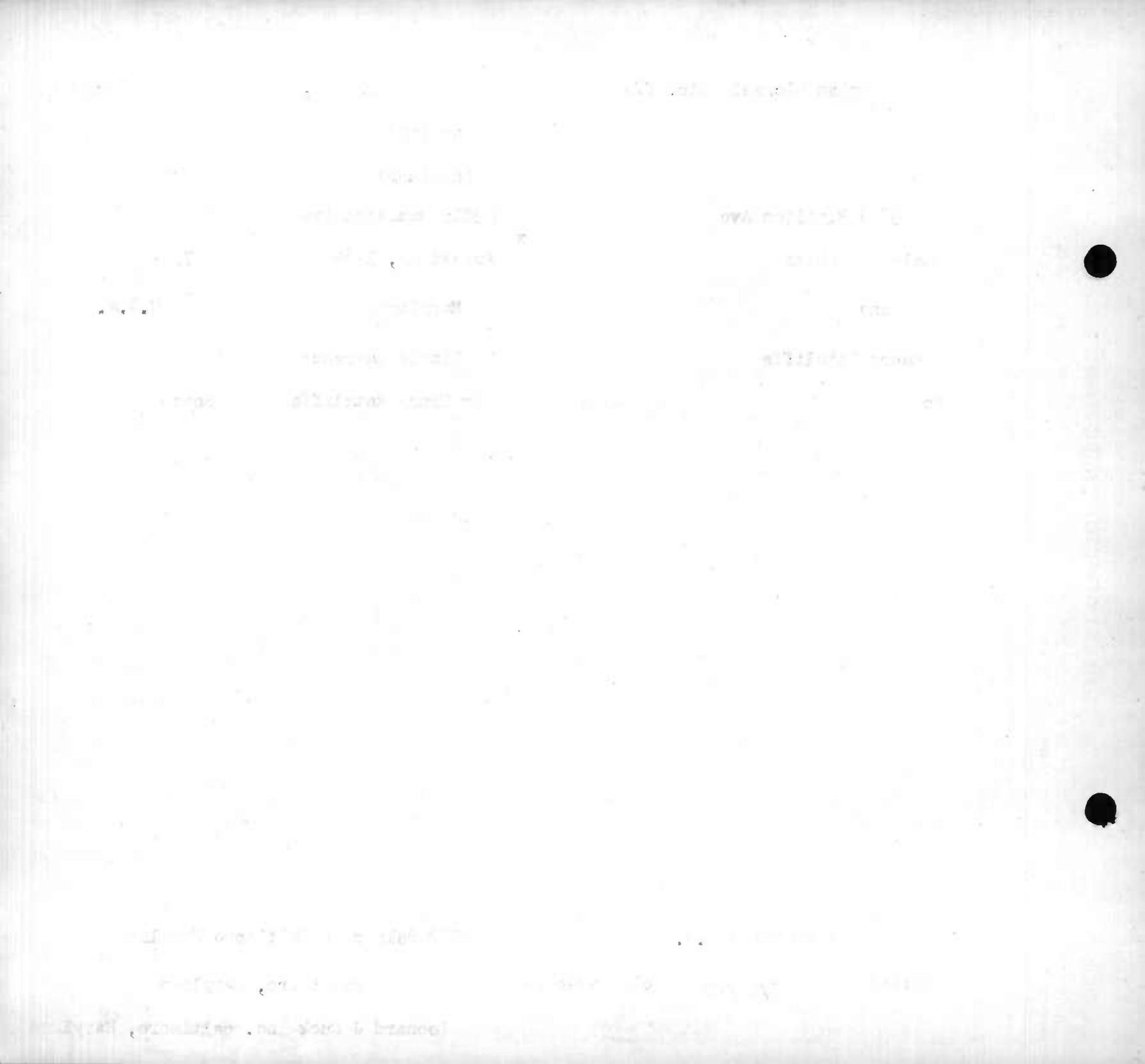
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10-10-10

# FUNERAL DIRECTOR: IMPORTANT

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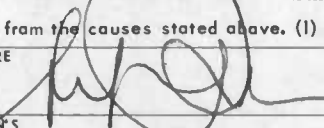
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3205</span>	
<div style="display: flex; justify-content: space-between;"> <span><i>R-324</i> 70 3205</span> </div>				<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>	
1. NAME OF DECEASED (Type or Print) <b>Brian Michael Ratcliffe</b>				2. DATE AND HOUR OF DEATH <b>March 25, 1970 12:30 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <span style="font-size: 1.5em;">2734</span>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
<span style="font-size: 1.5em;">00</span> <b>3819 H. Milton Ave</b>		<b>3819 Hamilton Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 25, 1969</b>	9. AGE (in years last birthday) <b>7</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Henry Ratcliffe</b>		
14. MOTHER'S MAIDEN NAME <b>Dianne Lawrence</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mr Henry Ratcliffe</b> ADDRESS <b>Same</b>		
18. <span style="font-size: 1.5em;">742X</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Diffuse cerebral damage</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hydrocephalus, congenital</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8-25-69</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Congenital Heart Disease</b>				<b>8-25-69</b>	
19A. DATE OF OPERATION <b>2.8.27-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hydrocephalus</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>April 1969</b> to <b>March 25, 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 25, 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Adam Swiss</b>				23B. DATE SIGNED <b>March 25, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Adam Swiss M.D.</b>				23D. ADDRESS <b>6232 Belair Rd Baltimore Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/28/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

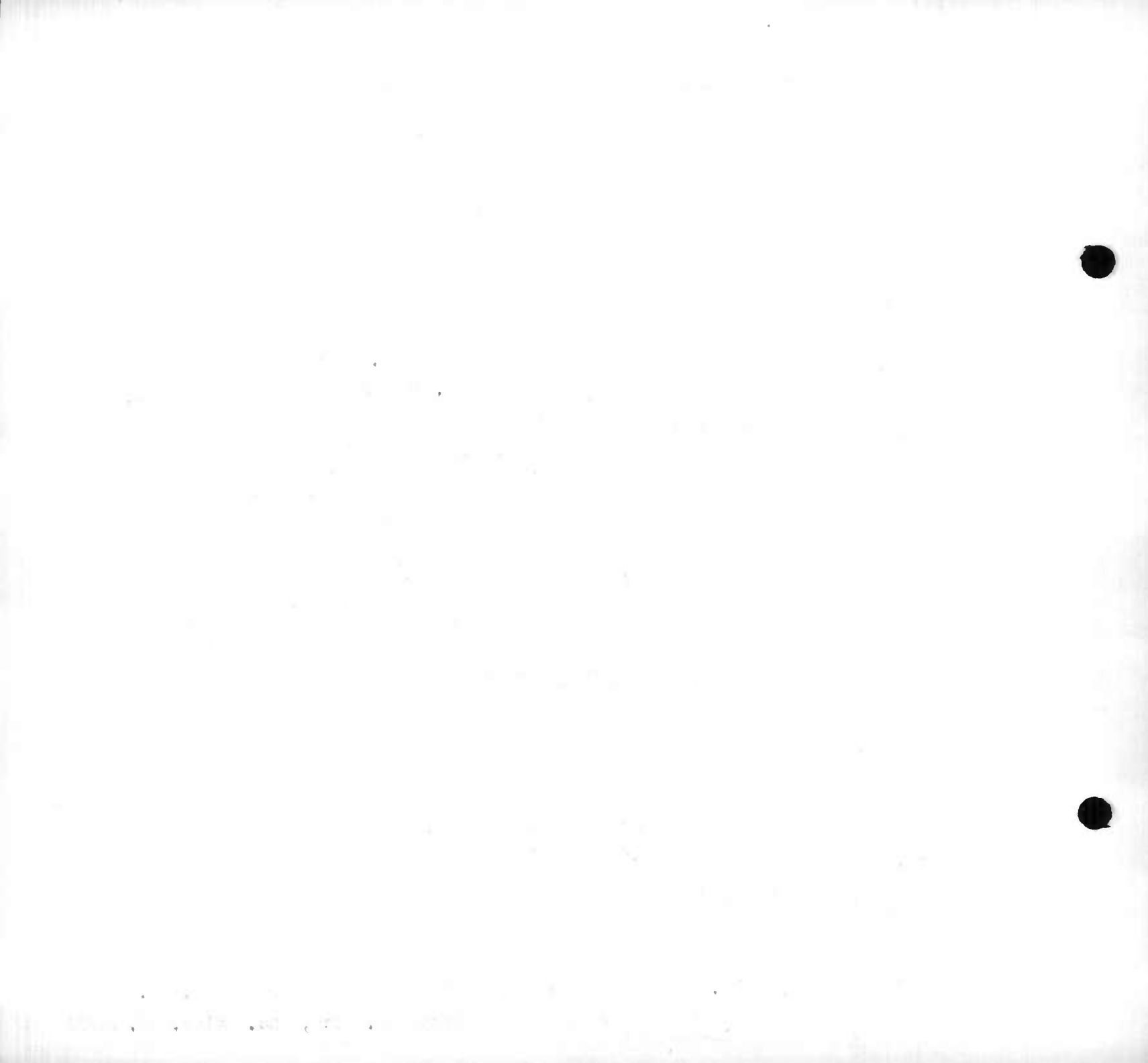
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3206</b>
E-152		70 3206		CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>Alfred Elmer Evans, Sr.</b>			2. DATE AND HOUR OF DEATH <b>March 24, 1970</b> <span style="float: right;">2 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2641</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4904 LaSalle Ave.</b>	
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1895</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Telegraph Operator Railroad</b>			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Gustavus Evans</b>	
14. MOTHER'S MAIDEN NAME <b>Susie M. Hatfield</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>705-05-7959</b>			17. INFORMANT <b>Mrs. Elizabeth Evans</b>	
18. CAUSE OF DEATH <b>41231</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ischemic</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). <b>Ischemic</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>2-12-64</b> to <b>2-12-70</b> that (I) (we) last saw the deceased alive on <b>2-12-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE  <b>Dr. Sebastian Russo M.D.</b>			23B. DATE SIGNED <b>3/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Sebastian Russo</b>			23D. ADDRESS <b>5017 Harford Road Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/28/70.</b>	24C. NAME of CEMETERY or CREMATORY <b>Springfield Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md.</b>		

1. *Staphylococcus aureus* (S. aureus)  
2. *Staphylococcus epidermidis* (S. epidermidis)  
3. *Staphylococcus saprophyticus* (S. saprophyticus)  
4. *Staphylococcus sciuri* (S. sciuri)  
5. *Staphylococcus carnosus* (S. carnosus)  
6. *Staphylococcus hyacinthi* (S. hyacinthi)  
7. *Staphylococcus albus* (S. albus)  
8. *Staphylococcus citreus* (S. citreus)  
9. *Staphylococcus gelae* (S. gelae)  
10. *Staphylococcus lentus* (S. lentus)  
11. *Staphylococcus pasteurii* (S. pasteurii)  
12. *Staphylococcus saprophyticus* (S. saprophyticus)  
13. *Staphylococcus sciuri* (S. sciuri)  
14. *Staphylococcus carnosus* (S. carnosus)  
15. *Staphylococcus hyacinthi* (S. hyacinthi)  
16. *Staphylococcus albus* (S. albus)  
17. *Staphylococcus citreus* (S. citreus)  
18. *Staphylococcus gelae* (S. gelae)  
19. *Staphylococcus lentus* (S. lentus)  
20. *Staphylococcus pasteurii* (S. pasteurii)

# FUNERAL DIRECTOR: IMPORTANT

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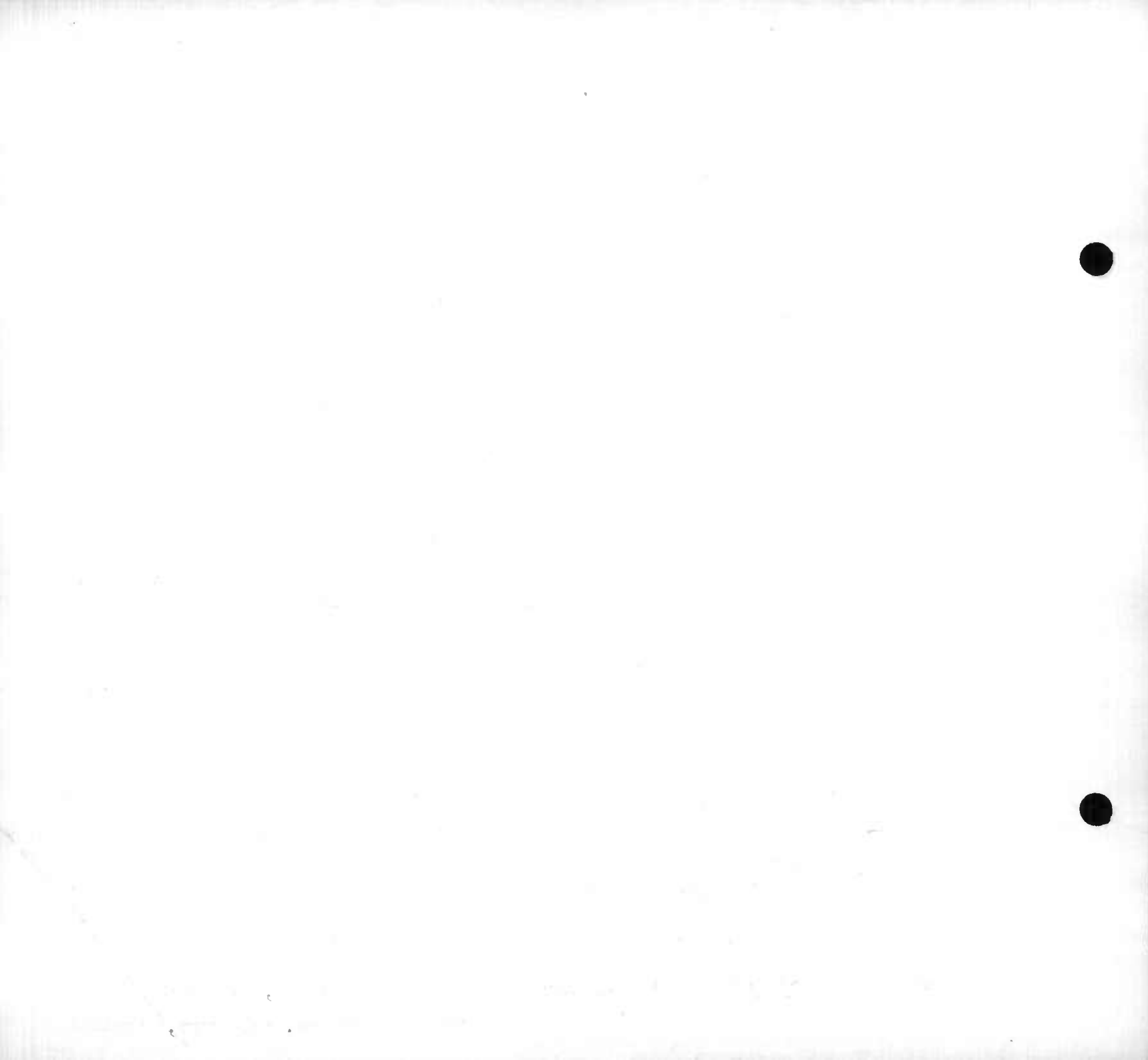
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3207</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">H-643 70 3207</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">FLORENCE L. HEROLD</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Mar 24 1970 13:35 P</span> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">2632</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">NORCH HOME &amp; HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="font-size: 1.2em;">5200 NUTT AVE</span>					
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">CAU</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/7/13</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOMEMAKER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">CLARENCE E. THOMAS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">IDA B. BROWN</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-32-7792</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Josephine Marston</span>	
ADDRESS <span style="font-size: 1.2em;">(Same)</span>					
18. <span style="font-size: 1.2em;">ARRIVE - BY AIRCRAFT</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">4/7/13</span>		CAUSE OF DEATH <span style="font-size: 1.2em;">Aneurysm abdominal</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">arteriosclerotic heart disease</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">arteriosclerotic heart disease</span> (C) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">arteriosclerotic heart disease</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">II</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">3/18/70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">abdominal aneurysm</span>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">July 1960</span> to <span style="font-size: 1.2em;">Mar 24 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Mar 24 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Donald W. Mintzer</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">3/24/70</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DONALD W. MINTZER</span>		23D. ADDRESS <span style="font-size: 1.2em;">3009 EVERGREEN AVE BALTIMORE MD</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/28/70.</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 26 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21211</span>	



# FUNERAL DIRECTOR: IMPORTANT

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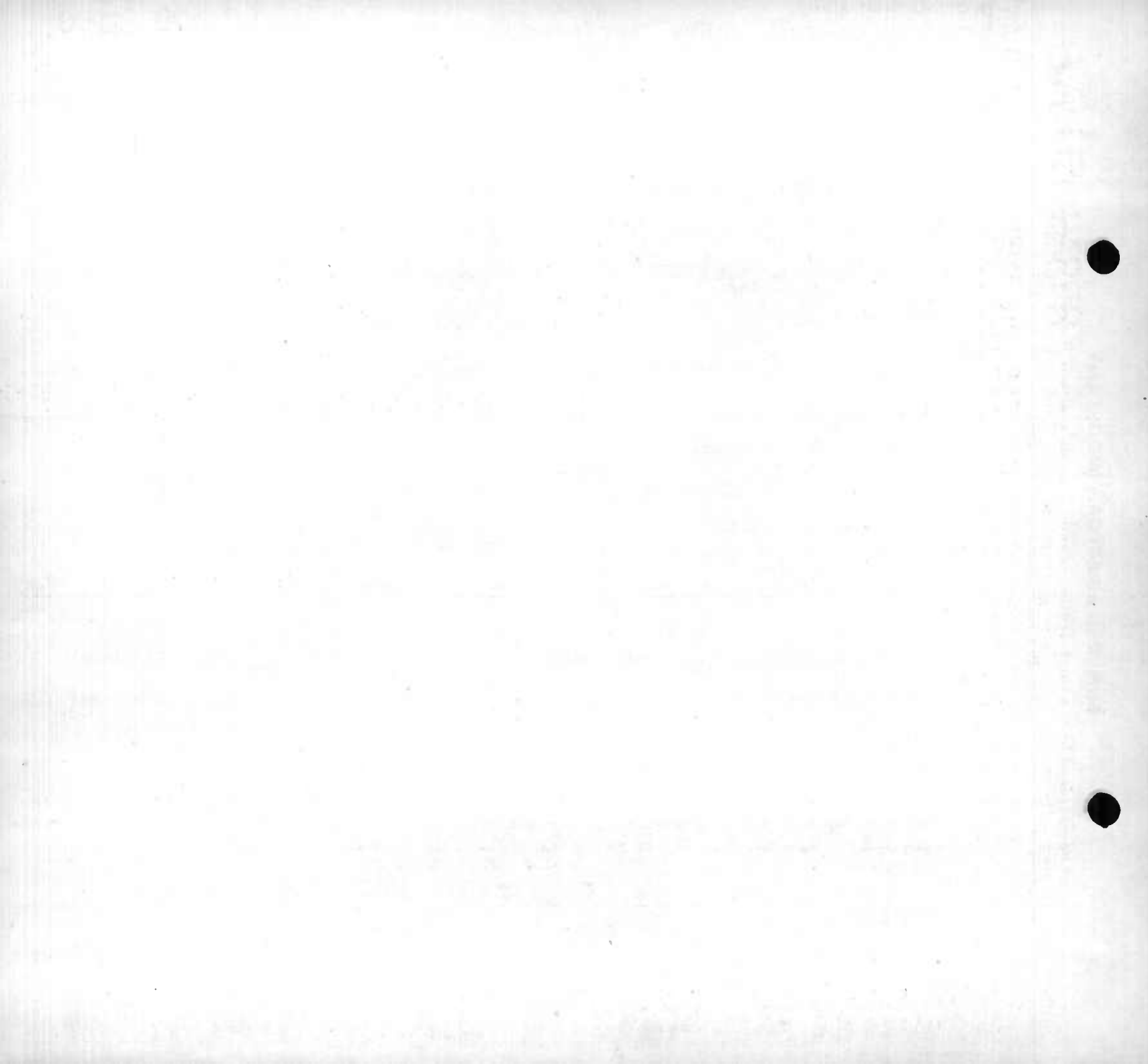
L-520 70 3208				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3208	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		LYNCH MARIE S.		3/24/70		625 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
UNIVERSITY OF MARYLAND Hosp.		3813 BALTIMORE RD 21201		1555 UPSHIRE RD. BALT MD 21218			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1555 UPSHIRE RD 21218		902	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-6-13	56			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				USA - Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES SNEARMAN				GERTRUDE THOMAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Hospital Recd			
18. 225701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				? CEREBRAL EDEMA			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				? HERNIATION OF THE PONS			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) PO. EXCISION MENINGIOMA OF THE CLIVUS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/17/70		Brain tumor		Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-17 1970 to 3-24 1970 that (I) (we) last saw the deceased alive on 3-24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M. H. Gonzalez M.D.							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
M. H. Gonzalez M.D.		University of Md. Hosp. Baltimore Md 21201					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/28/70		Holy Redeemer		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 26 1970		Robert J. ...		Leonard J Ruck Inc.		Baltimore, Maryland	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3209	
C-200 70 3209					
BIRTH NO.			1. NAME OF DECEASED (Type or Print) Margaret COX		
2. DATE AND HOUR OF DEATH 20 May 70 4:50 P.M.			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION 70 Fayette Convalescent Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balt C. CITY OR TOWN Balt D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3057 Stafford Ave		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Jan 20	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Geo Hales		
14. MOTHER'S MAIDEN NAME Emma Childs			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MRS. LILLIAN STEWARD ADDRESS 2669 HAFERST BALD. MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF and 20 min		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Post Traumatic Retardation sexual yn (C) Old injury (ma fall) 20 yr ago		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7 Sep 1968 to 20 Mar 1970, that (I) (we) last saw the deceased alive on 20 Mar 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J Hulla MD			23B. DATE SIGNED 20 Mar 70		
23C. PHYSICIAN'S NAME (Type) J Hulla MD			23D. ADDRESS 2214 E Fayette St 21281		
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-70		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR GEO. L. SCHWAB 2101 FRED'K AVE.			

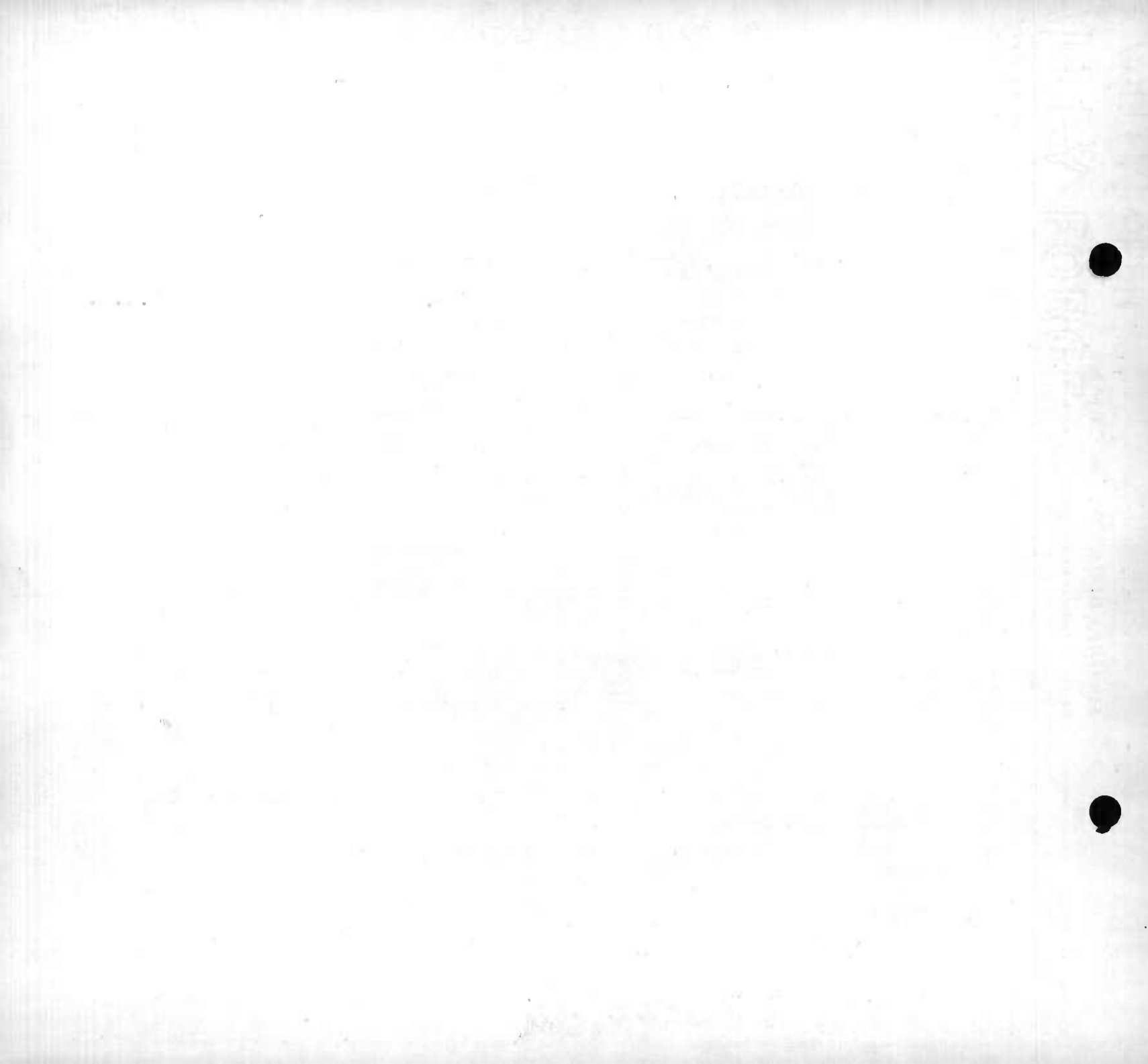




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3210</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3210</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Norman J. Smallwood</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-24-70</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">00 2309 Dukeland St.</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">2309 Dukeland St.</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negroid</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-20-09</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">60</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">B&amp;O RAILROAD</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Wilbert Smallwood</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Henrietta</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Agnes Smallwood</span>	
18. <span style="font-size: 1.2em;">16 21 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Metastasis Pulmonary Cancer</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">15 months</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-27-1968</span> to <span style="font-size: 1.2em;">March 24, 1970</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 24, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Percival C. Smith</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">March 24, 1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Percival C. Smith, M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">4200 Edmondson Avenue</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3-28-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Arbutus Mem. Park</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE OF BURIAL <span style="font-size: 1.2em;">MAR 26 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Bailey</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">V. Bailey</span>			
25D. ADDRESS <span style="font-size: 1.2em;">Kelson FH. 1348 Calhoun Street</span>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3211		REG. NO. 70 3211	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Farr, Annie</b>				2. DATE AND HOUR OF DEATH <b>3-24-70 6:35 a. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1503</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1733 Thomas Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-09</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Walter Fielder</b>			
14. MOTHER'S MAIDEN NAME <b>Lillie West</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-10-1096</b>				17. INFORMANT ADDRESS <b>Mrs. Lillian Gregory 1825 Kavauaugh St</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>2307</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>3-6-70</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetic Gangrene Left Foot</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>2-19-70</b> 19 to <b>3-24-70</b> 19 that (I) (we) last saw the deceased alive on <b>3-24-70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <i>Dr. G. Franklin Phillips</i> 23B. DATE SIGNED <b>3-24-70</b> 23C. PHYSICIAN'S NAME (Type) <b>Dr. G. Franklin Phillips</b> 23D. ADDRESS <b>558 McMechan Street - Baltimore, Maryland</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 days</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3/27/70</b>			
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Arundel County, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>				ADDRESS <b>1348 N. Calhoun St.</b>			



S-363

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70 3212

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

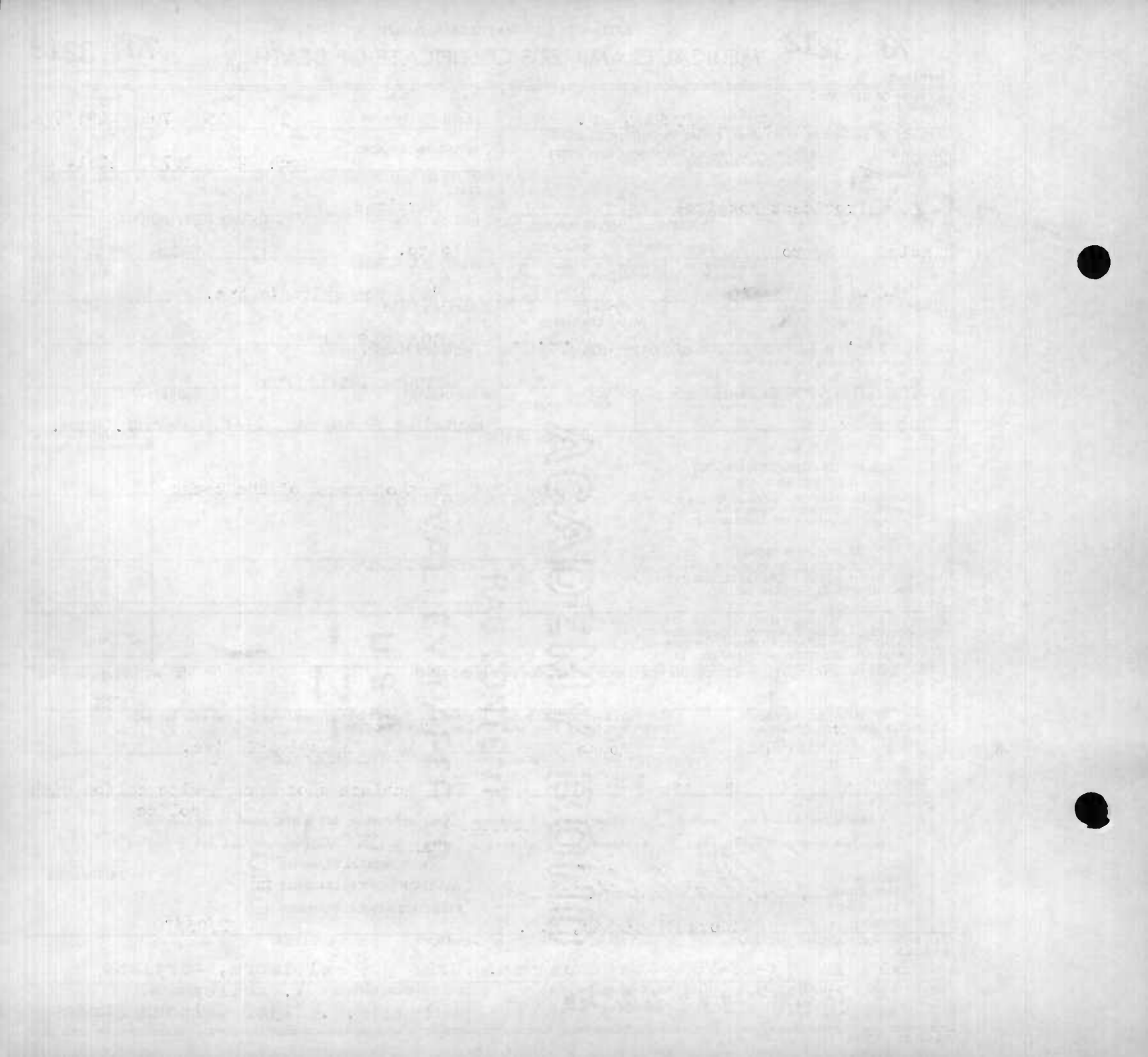
REG. NO.

70 3212

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES STEWART Jr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>3 25 70</b>		Hour <b>12:14 a.m.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 25, 1970</b>		Hour <b>12:14 a.m.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>8-2-43</b>		10. AGE (In years lost birthday) <b>26</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Stewart</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>
15. MOTHER'S MAIDEN NAME <b>Bertha Brailford</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Rosalie Stewart</b>		19. CAUSE OF DEATH <b>E-970X</b>		20. DATE OF OPERATION
21. AUTOPSY? (Yes or No) <b>YES</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		23. TIME OF INJURY (APPROX.) <b>3 24 70 12am</b>
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		25. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		26. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>
27. FUNERAL DIRECTOR <b>Kelson F.H.</b>		28. ADDRESS <b>1348 Calhoun Street</b>		29. DATE SIGNED <b>3/25/70</b>

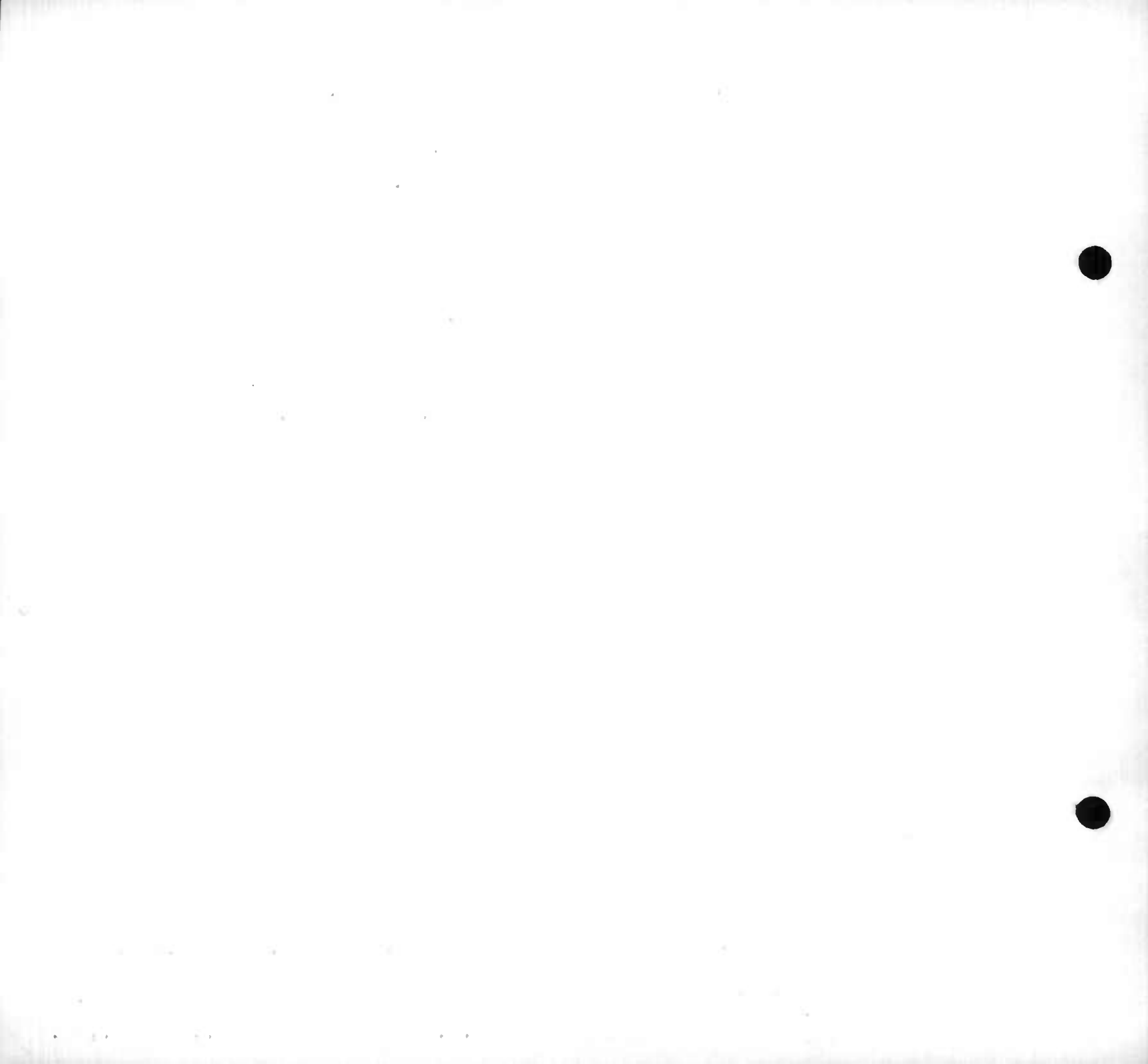
MEDICAL CERTIFICATION



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3213		REG. NO. 70 3213	
BIRTH NO. 70 3213				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>EMMA B. SLADE</b>				2. DATE AND HOUR OF DEATH <b>Mar. 24, 1970</b> 18 <sup>15</sup> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 22 Charlcote Place</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2711</b>			
				C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>22 Charlcote Place</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-25-1890</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Hugo Koch</b>				
14. MOTHER'S MAIDEN NAME <b>Rebecca Schmidt</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>215-22-8172</b>			17. INFORMANT <b>Mrs. Dorothy S. Durkee</b>				
18. ADDRESS <b>Same</b>			18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized arteriosclerosis</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>7 years</b>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Carcinoma of breast</b>						<b>6 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 63</b> to <b>Mar 24 19 70</b> that (I) (we) last saw the deceased alive on <b>Mar 23 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Franklin E. Leslie</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/25/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Franklin E. Leslie MD</b>				23D. ADDRESS <b>3501 St. Paul St., Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>		24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>			





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T-460 70 3214

BALTIMORE CITY HEALTH DEPARTMENT

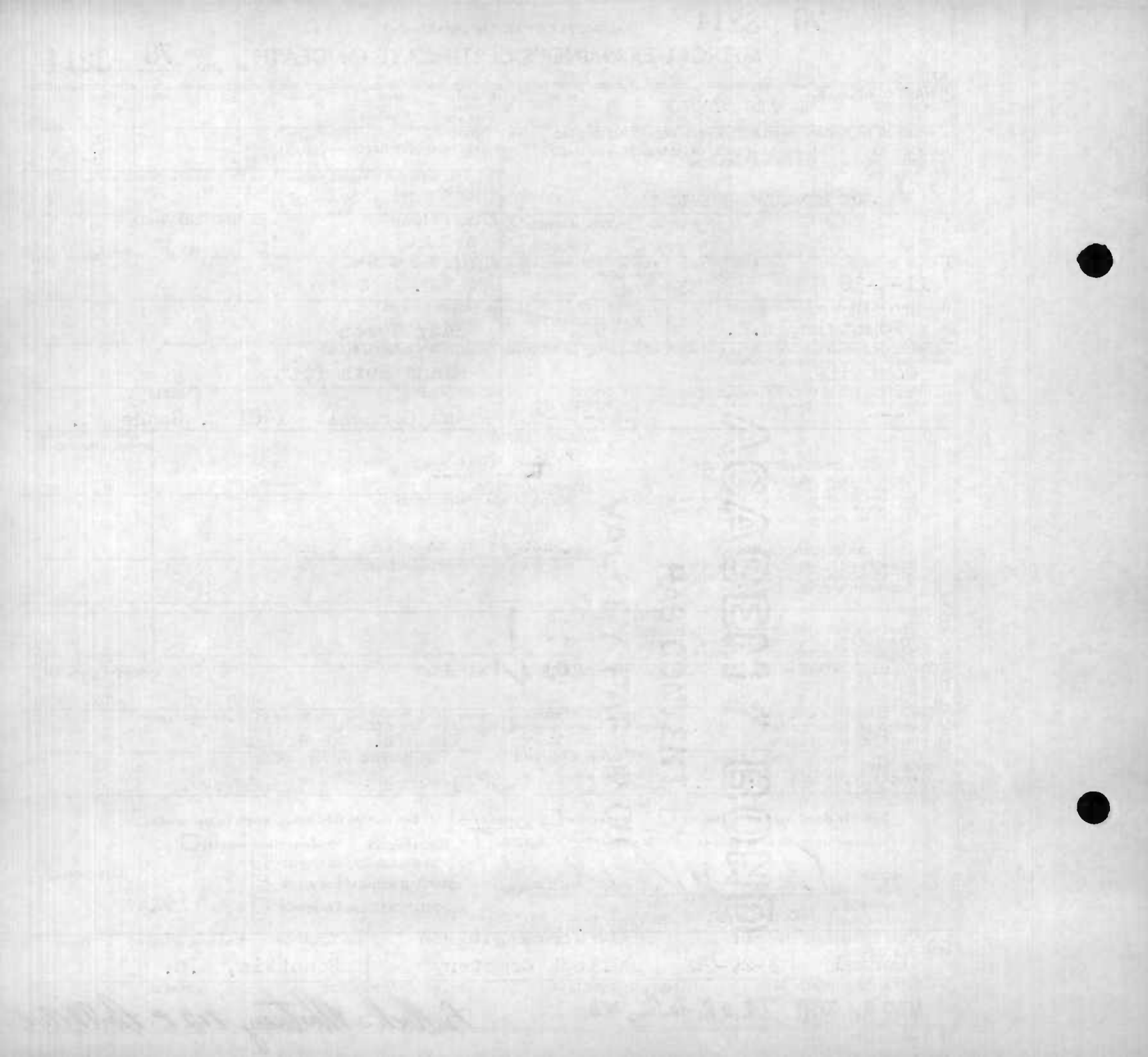
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3214

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year March 21, 1970 2:25 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 11-4-36		10. AGE (In years last birthday) 33	E. STREET AND NUMBER 442 E. 20th Street
11. BIRTHPLACE (State or foreign country) Fountain, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Eddy Tyson
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costodian		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Nanna Ruth Pitt			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NA		17. SOCIAL SECURITY NO. 240-52-8937	18. INFORMANT Ann Cornwell
		ADDRESS 1901 E. Boone St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Exsanguination (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Shotgun wound of Right Leg DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hallway	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 442 E. 20th Street 1204		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3-21-70 1:53 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found lying in hallway	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/21/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-29-70	24C. NAME OF CEMETERY or CREMATORY Bullock Cemetery	24D. LOCATION (City, town, or county) (State) Fountain, N.C.
25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970		25B. NAME OF REGISTRAR Robert E. Farber, R.D.	25C. FUNERAL DIRECTOR Bullock's Mortuary
		ADDRESS 712 E. South Ave.	

VS 151-REV. 7/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3215		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 3215	
1. NAME OF DECEASED (Type or Print) <b>Chester Holmes</b>			2. DATE AND HOUR OF DEATH <b>Mar. 22, 1970 6:20 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ga.</b> B. COUNTY <b>V-09</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Meridian</b> D. STREET ADDRESS (If rural, give location) <b>PO Box 42</b>		
5. SEX <b>M</b>	6. RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/13/1918</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Skipper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafaring</b>		11. BIRTHPLACE (State or foreign country) <b>Ga.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Moses Holmes</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude Sams</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT ADDRESS <b>US PHS Hospital, Balto, Md.</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Squamous cell ca of lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
			(B) DUE TO		
			(C) <b>Pneumonia</b>		<b>3 weeks</b>
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic anemia</b>					
19A. DATE OF OPERATION <b>1/3/6/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>For diagnosis Bronchoscopy &amp; Esophagoscopy &amp; bx</b>		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28 19 70</b> to <b>Mar. 22 19 70</b> , that (I) (we) last saw the deceased alive on <b>Mar. 22 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wilmer J. Keener</b>				23B. DATE SIGNED <b>3/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wilmer J. Keener, SA Surg (R)</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>3/25/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Meridian</b>	
24D. LOCATION (City, town, or county) (State) <b>Meridian Ga.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Washington Phillips 1727 N. Monmouth St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. <u>R-300</u> <u>70</u> <u>3216</u>					CERTIFICATE OF DEATH					REG. NO. <u>70</u> <u>3216</u>						
1. NAME OF DECEASED (Type or Print) <u>Reth, Laurence Killian</u>					2. DATE AND HOUR OF DEATH <u>March 23, 1970</u> <u>10:35</u> <u>PM</u> M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Pa.</u> B. COUNTY <u>V-35</u>											
					C. CITY OR TOWN <u>McSherrystown</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
					E. STREET AND NUMBER <u>623 Main St.</u>											
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-13</u>		9. AGE (In years last birthday) <u>57</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Auditor</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>					11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Peter Reth</u>					14. MOTHER'S MAIDEN NAME <u>Fannie HIGDON</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>NO</u>					16. SOCIAL SECURITY NO. <u>189-07-0707</u>					17. INFORMANT <u>Mary Lenore Reth</u> <u>623 Main St</u> ADDRESS <u>Mc Sherrystown, Pa</u>						
18. <u>4-10-9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>  (B) <u>with Ventricular Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>  <u>2 mo.</u>		
MEDICAL CERTIFICATION																
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> 19 <u>70</u> to <u>March 23</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>March 23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <u>Richard O'Brien, M.D.</u>								23B. DATE SIGNED <u>3/23/70</u>								
23C. PHYSICIAN'S NAME (Type) <u>Richard O'Brien, M.D.</u>								23D. ADDRESS <u>University Hospital</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>3/27/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>annunciation Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Mc Sherrystown Adams Co Pa</u>						
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 26 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>				25C. FUNERAL DIRECTOR <u>Tipton-Elmer</u>				ADDRESS <u>Hempstead, Md.</u>				

University Hospital

M. W. T.

John Smith

Peter Kirk

Johnson

1-30-13 27  
223 Main St.  
The University

Farrar

Myocardial Infarction

with Ventricular Arrhythmia

March 23, 1913

Richard O. Brown, M.D.

University Hospital

March 23, 1913

X 2/2/13

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 70 3217		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	70 3217
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHNSON, MAXWELL		March 22, 1970 5:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
Lutheran Hospital		Maryland		1607	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2709 Winchester St			
5. SEX	6. RACE	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
male	negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8-19-83	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABOR		VARIOUS		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A		JOSEPH JOHNSON		ANNIE BROWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218-16-5034		SAMUEL JOHNSON WORTON, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Pneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic Heart Disease			
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		3-21 1970 to 3-23 1970			
that (I) (we) last saw the deceased alive on		3-22 1970 and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Violeta R. Gamarras MD		3-22-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
VIOLETA R. GAMARRAS R. MD		730 Ashburton St Bal. Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3/28/1970		FOUNTAIN CEMETERY	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
R.F.D. WORTON, KENT. MD		Benetalla		CHESTER TOWN, MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 26 1970		R. E. F. R.		Benetalla	

June 5 - 1919, 7:00 P.M. High  
Water 2.00 m. 7.00 m. 2.00 m. 6.00 m.  
June 6 - 1919, 7:00 P.M. High  
Water 2.00 m. 7.00 m. 2.00 m. 6.00 m.

June 7 - 1919, 7:00 P.M. High  
Water 2.00 m. 7.00 m. 2.00 m. 6.00 m.



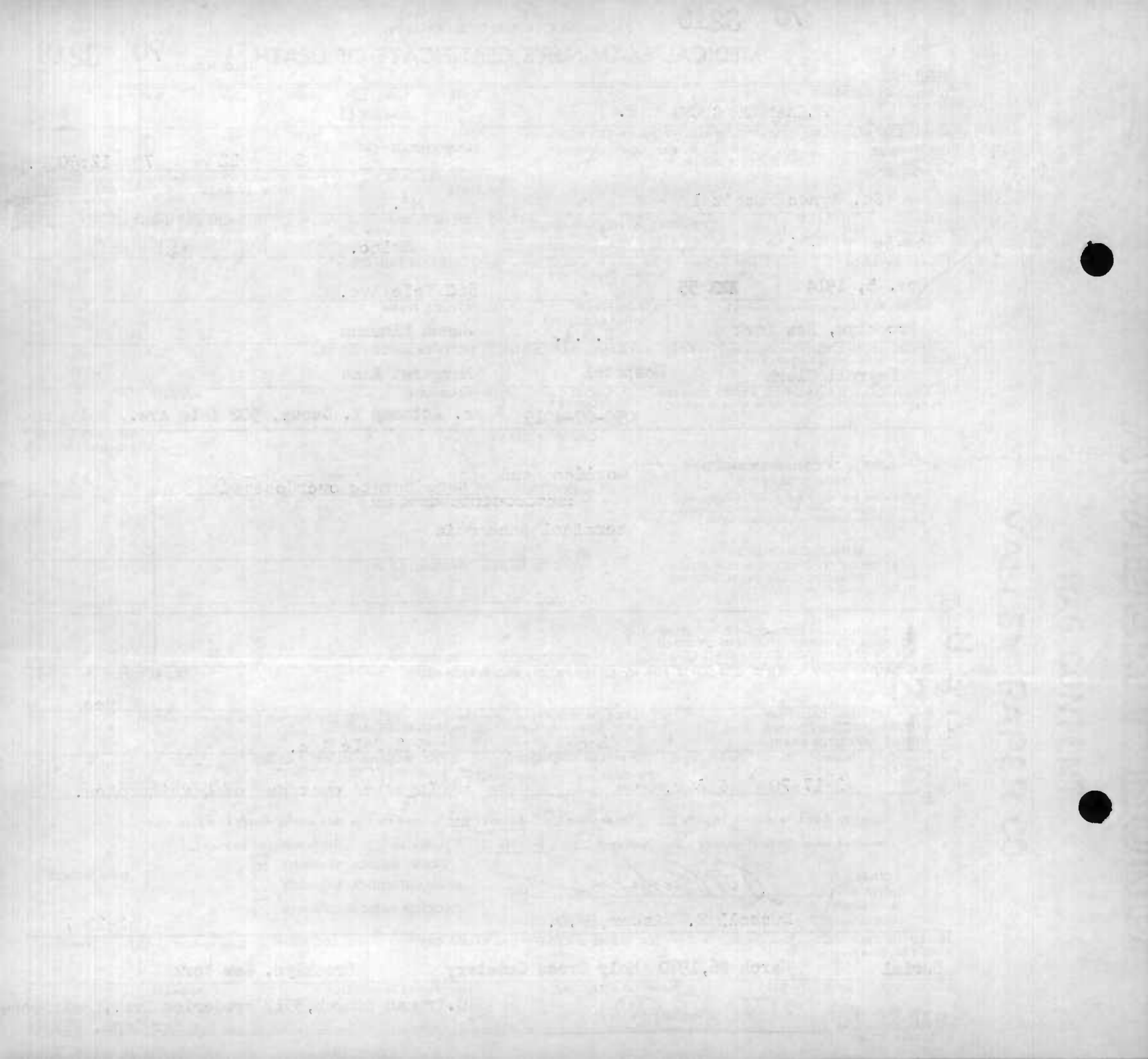
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3218</span>	
F-624 <span style="font-size: 1.5em;">70 3218</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mr Warner FRIZZELL</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">March 21, 1970</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">00</span> <span style="font-size: 1.2em;">5802 Woodcrest Ave.</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">2719</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Balto.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">5802 Woodcrest Ave.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">Jan. 18, 1906</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">64</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Title Guarantee Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Catonsville, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Ira R. Frizzell</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Knight Warner</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-05-0591</span>			
17. INFORMANT <span style="font-size: 1.2em;">Balto. Md. 21215</span> <span style="font-size: 1.2em;">Mrs. Helen C. Frizzell 5802 Woodcrest Ave.</span>		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.5em;">3310</span> <span style="font-size: 1.2em;">Mucine GI hemorrhage</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">Bleeding peptic ulcer, pylorus</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">hours</span>  <span style="font-size: 1.2em;">years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <span style="font-size: 1.2em;">No</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <span style="font-size: 1.2em;">In Baltimore City, give exact location</span>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">LAWRENCE C. STINGHAMER MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">3-21-70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">LAWRENCE C. STINGHAMER MD</span>	
23D. ADDRESS <span style="font-size: 1.2em;">BON SECOURS HOSP.</span>		24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <span style="font-size: 1.2em;">March 24, 1970</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Woodlawn cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn, Balto. Md.</span>	
25A. DATE RECD BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 26 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. ...</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Balto. Md. 21229</span> <span style="font-size: 1.2em;">G. Truman Schwab 5151 Balto. National Pike</span>	



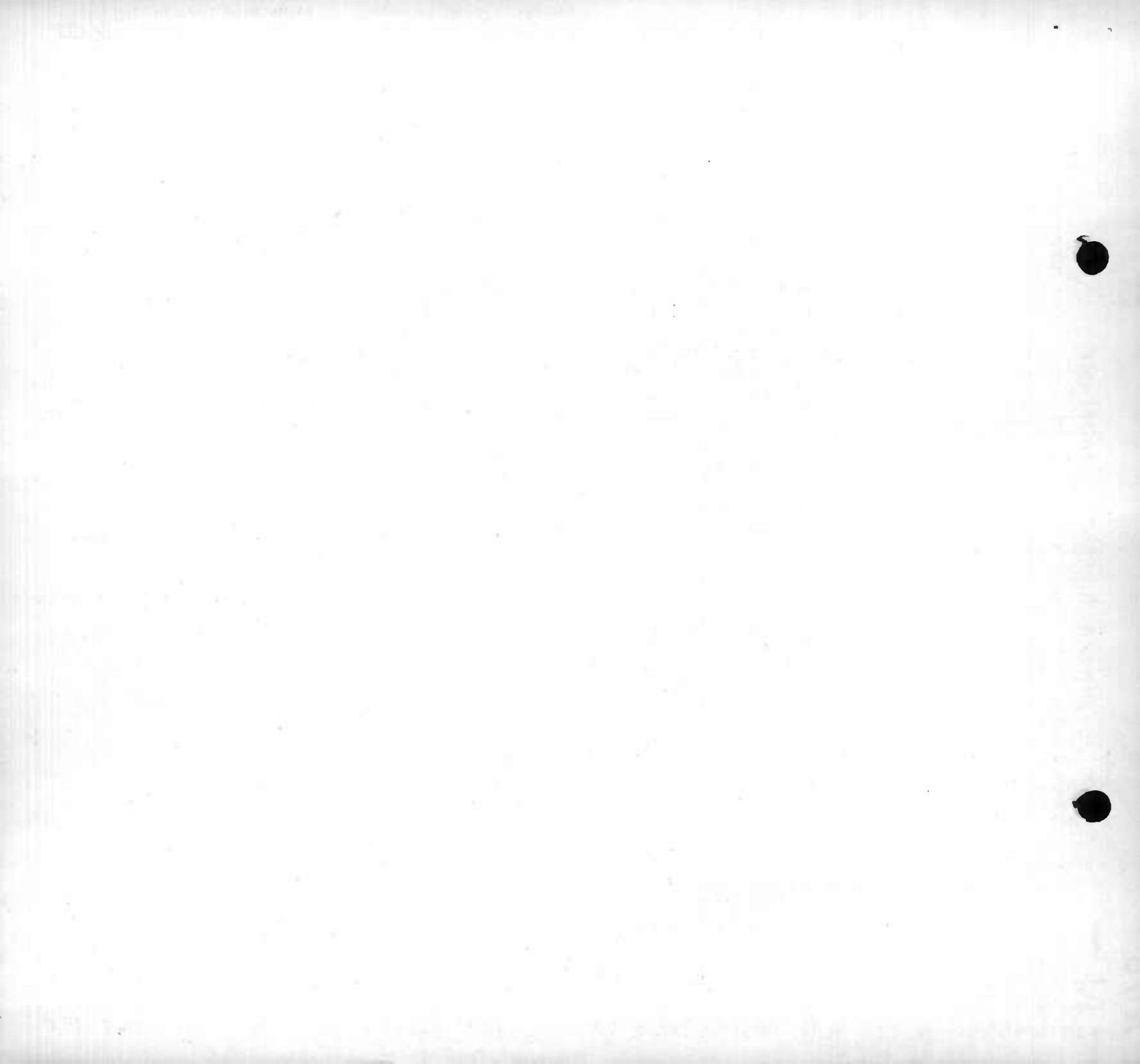
BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3219			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) ELIZABETH GUCWA P.						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital						3. DATE PRONOUNCED DEAD Month Day Year Hour 3 22 70 12:40 P.M.					
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 2541											
6. SEX Female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Nov. 5, 1914		10. AGE (in years last birthday) 55		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 502 Yale Ave.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll Clerk				14B. KIND OF BUSINESS OR INDUSTRY Hospital		13. FATHER'S NAME James Kinahan					
15. MOTHER'S MAIDEN NAME Margaret Ashe				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 059-07-4915		18. INFORMANT Mr. Anthony T. Gucwa, 502 Yale Ave., Baltimore			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Doriden and (A) IMMEDIATE CAUSE Barbiturate overdose with terminal pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 502 Yale Ave. 2541			
22D. TIME OF INJURY (APPROX.) 3-17-70 5:40 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Ingested overdose of barbiturates.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell E. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-23-70											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE March 26, 1970		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery				24D. LOCATION (City, town, or county) (State) Brooklyn, New York	
25A. DATE REC'D BY HEALTH DEPT. MAR 26 1970				25B. NAME OF REGISTRAR R. E. Fisher, M.D.				25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab, 3512 Frederick Ave., Baltimore Maryland, 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3220</span>	
1-160 70 3220		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<i>Joseph Libauer</i>		<i>March 23 1970 3 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>00 2418 W. Rogers Avenue</i>			A. STATE <i>Maryland</i>		
			B. COUNTY <i>2755</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>2418 W. Rogers Ave</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 24, 1876</i>	9. AGE (In years last birthday) <i>93</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wolf Lipovsky</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-26-6117</i>		17. INFORMANT <i>Selina Libauer - 2418 W. Rogers</i>	
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes Mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>Years</i> <i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1969</i> to <i>March 23 1970</i> , that (I) (we) last saw the deceased alive on <i>March 22 1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David D. Miller M.D.</i>				23B. DATE SIGNED <i>March 24-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. DAVID MILLER</i>				23D. ADDRESS <i>9115 Reisterstown Rd. Owings Mills, Md</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 24/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Beth Tfilah</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodson, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>	
25C. FUNERAL DIRECTOR <i>Sal Johnson Inc</i>		25D. ADDRESS <i>6010 Reister Rd</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3221		REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <u>Anna Goodman</u>				2. DATE AND HOUR OF DEATH <u>22 March 1970</u>   <u>5 50</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u> <u>Baltimore, Maryland 21205</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>1206</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2428 MARYLAND AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-97</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: _____ Days: _____	If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SEAFORD, DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL GOODMAN</u>				14. MOTHER'S MAIDEN NAME <u>DOLLY KOLESKI</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-14-9613</u>		17. INFORMANT <u>MISS HELEN GOODMAN, 2428 MARYLAND AVE. #18</u>			
18. CAUSE OF DEATH <u>3-40-10</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Appendicitis with perforation, peritonitis + sepsis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute renal failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Diffuse gastrointestinal bleeding, Recent pulmonary edema -&gt; (3 weeks) and LEFT hemiparesis, Semicomatose, jaundice - pyelonephritis.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>2 weeks</u> <u>~ 5 years</u>			
MEDICAL CERTIFICATION							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>Diffuse gastrointestinal bleeding, Recent pulmonary edema -&gt; (3 weeks) and LEFT hemiparesis, Semicomatose, jaundice - pyelonephritis.</u>							
19A. DATE OF OPERATION <u>2/29/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Appendicitis + perforation</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>NONE</u>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 15</u> 19 <u>70</u> to <u>MARCH 22</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>MARCH 22</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>James W. Forster, M.D.</u>				23B. DATE SIGNED <u>22 MARCH 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>JAMES W. FORSTER M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-24-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			





# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>M-623</span> <span>70 3222</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.2em;">70 3222</span>	
BIRTH NO. <span style="font-size: 1.2em;">M-623</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MARCH 23, 1970 5:00 P. M.</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LAURA MARGOT</span>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">LEVINDALE HEBREW HOME 91 AND INFIRMARY</span>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2717</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">FEMALE</span>		6. RACE <span style="font-size: 1.2em;">WHITE</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">80</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">80</span>		10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">RUSSIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">? PERLMAN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">SARAH ?</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. BETTY PRELL, 3733 McDONOUGH RD. #21133</span>	
18. <span style="font-size: 1.2em;">412.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">CONGESTIVE HEART FAILURE</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ARTERIOSCLEROTIC CARDIO - VASCULAR DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">8 hours</span> <span style="font-size: 1.2em;">more than 8 years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">May 2 1963</span> to <span style="font-size: 1.2em;">March 23 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 23 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Elsa R. Merani, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">March 23, 1970</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ELSA R. MERANI, M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">3-25-70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">MIKRO KODESH BETH ISRAEL</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 26 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sol Levinson</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>			

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**FUNERAL DIRECTOR: IMPORTANT**

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<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70 3223</b></p>	
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>MYRON M. KAHN</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>3-24-70 2:23A.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GEN-HOSP</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1401</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>SUTTON PLACE, APT. 807, 1111 PARK AVENUE #1</b></p>	
<p><b>5. SEX</b> <b>MALE</b></p>	<p><b>6. RACE</b> <b>CAUCASIAN</b></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>2-23-1904</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>BALTO. SYMPHONY</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>66</b></p> <p><b>11. BIRTHPLACE</b> (State or foreign country) <b>ROMANIA</b></p>
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>		<p><b>13. FATHER'S NAME</b> <b>? KAHN</b></p>	
<p><b>14. MOTHER'S MAIDEN NAME</b> <b>BESHEBA ?</b></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>	
<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b> <b>MRS. ANN KAHN, 1111 PARK AVENUE #21201</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/10.9 I</b></p>		<p><b>CAUSE OF DEATH</b> <b>Acute Myocardial infarct</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease - previous infarct</b></p> <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>3 years ago</b></p> <p><b>(C) _____</b></p>	
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>NONE</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>1/2 HR</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>0 -</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>-</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>-</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>-</b></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b></p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> <b>-</b></p>		<p>(If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>-</b></p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b> <b>-</b></p>		<p><b>22. I certify that (1) (this hospital) attended the deceased from 2-5 1968 to 3-24 1970, that (1) (we) lost saw the deceased alive on 3-19 1970 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. Pronounced in HOSPITAL</b></p>	
<p><b>23A. SIGNATURE</b> <b>H. Gerard Oster MD</b></p>		<p><b>23B. DATE SIGNED</b> <b>3/24/70</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>H. Gerard Oster MD</b></p>		<p><b>23D. ADDRESS</b> <b>6821 Reisterstown Rd Baltimore</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b></p>	<p><b>24B. DATE</b> <b>3-25-70</b></p>	<p><b>24C. NAME of CEMETERY or CREMATORY</b> <b>HEBREW FRIENDSHIP</b></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 26 1970</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor R.D.</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b></p>		<p><b>ADDRESS</b></p>	

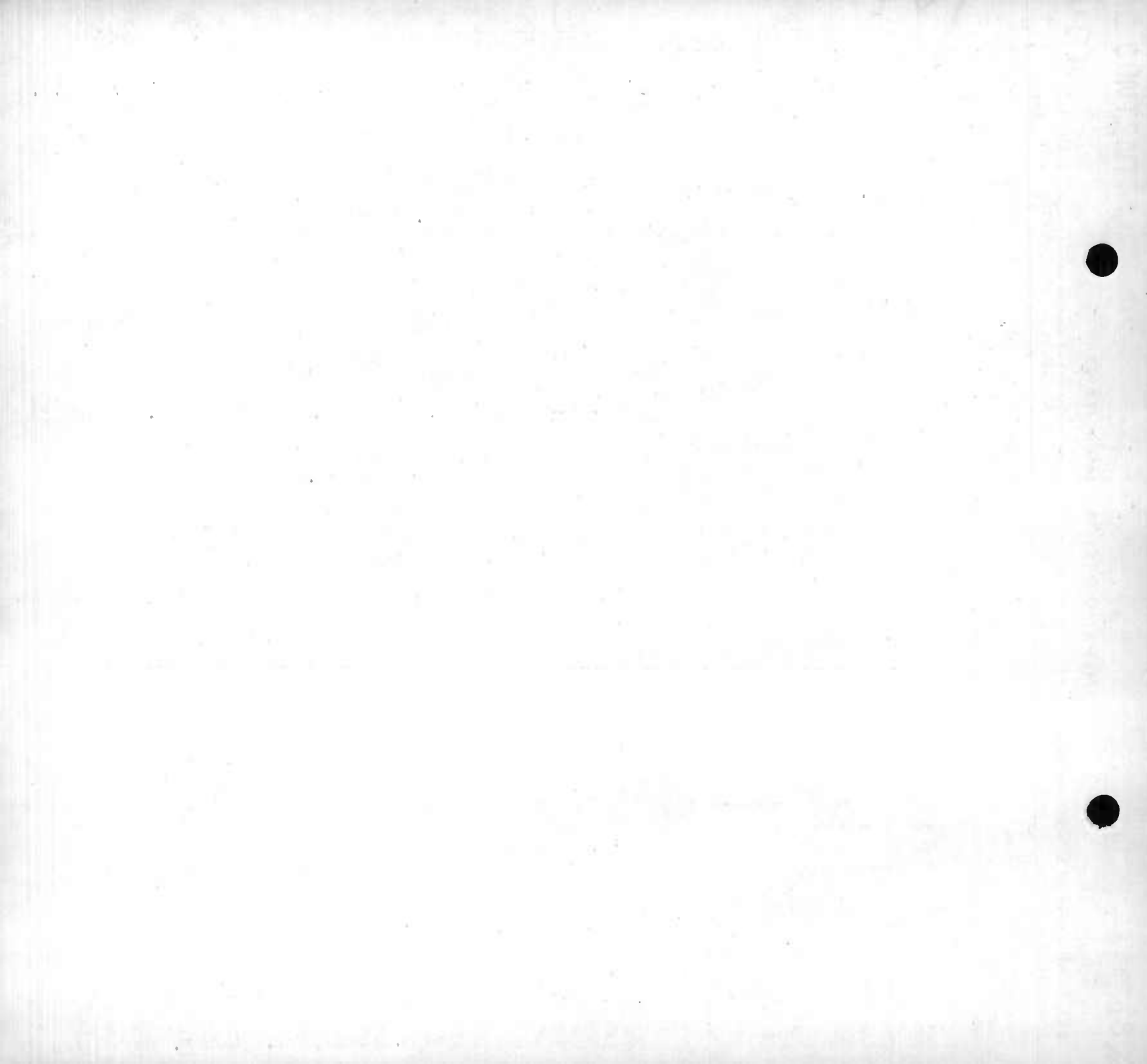
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-350		70 3224		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3224	
1. NAME OF DECEASED (Type or Print) <b>David Joseph Bettini</b>				2. DATE AND HOUR OF DEATH <b>March 24, 1970</b>   <b>4:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>601</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>30 N. Linwood Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/10/19</b>	9. AGE (In years last birthday) <b>70 69</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Method's Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-5549</b>		17. INFORMANT <b>Mrs. Evelyn M. Bettini</b> ADDRESS <b>30 N. Linwood Ave</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Myocardial Infarction</b> <b>Edema</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan - 18 1956</b> to <b>Feb - 5 1970</b> , that (I) (we) last saw the deceased alive on <b>Feb - 5 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William G. Geyer</b>				23B. DATE SIGNED <b>Mar-25-70</b>		23C. PHYSICIAN'S NAME (Type) <b>WM. G. GEYER MD</b>	
23D. ADDRESS <b>156 N. MILTON AVE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/27/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b> ADDRESS <b>3000 E. Baltimore St</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-645 70 3225		BALTIMORE CITY HEALTH DEPARTMENT		70 3225	
1		REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		David Berlin		3/23/70 4:40 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md		1301	
Sinei Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		Balto		E. STREET AND NUMBER	
		837 Lake Drive		Belvedere Ave at Greenspring.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W		9/19/87	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ret				Russian	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Sinei Hospital	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Myocardial Infarction	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD - DUE TO, OR AS A CONSEQUENCE OF:			
(C) U.T.I.		(D) POROPLEGIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/23/70 to 3/23/70 that (I) (we) last saw the deceased alive on 3/23/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
MD.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		3/23/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
Carlos R. Perel		Belvedere Ave at Greenspring.		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Sharon T. Philo		Balto Md		MAR 26 1970	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
Robert E. ...		Sydney Lewis & Son		9610 Reisterstown Rd	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3226	
BIRTH NO. K-560 70 3226		1. NAME OF DECEASED (Type or Print) KNAUER, WALTER E.		2. DATE AND HOUR OF DEATH 23 MARCH 70 3:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
JOHNS HOPKINS HOSPITAL 33		MARYLAND Dorchester 5900		CAMBRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		RFD #2					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-04	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		Building		Kansas		USA	
13. FATHER'S NAME AUGUST F. KNAUER				14. MOTHER'S MAIDEN NAME MARGARET FESSLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Md. LeCompte Funeral Service records, Cambridge,			
18. 399.91		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		NOT ME CASE					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		HEMORRHAGIC SHOCK					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) AORTIC VALVE REPLACEMENT DUE TO, OR AS A CONSEQUENCE OF:					
		SEVERE CALCIFIC AORTIC VALVULAR DISEASE					
II		CORONARY ARTERY DISEASE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 1/3/23/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC VALVE REPLACEMENT		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3/23/70 6:30 AM to 3/23/70 3:45 PM, that (I) (we) last saw the deceased alive on 3/23/70 3:45 PM, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ARTHUR B. JENNY MD				3/23/70			
23C. PHYSICIAN'S NAME (Type) ARTHUR B. JENNY				23D. ADDRESS			
				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/26/70		Dorchester Memorial Park		Cambridge, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 26 1970		Blair E. Fisher MD		LeCompte Funeral Service, Cambridge, Md.			

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3227</u>	
BIRTH NO. <u>S-636 70 3227</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ANTOINE Nmi Sartori</u>		2. DATE AND HOUR OF DEATH <u>3/23/70 1140 pm</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE DECEASED LIVED <b>CERTIFICATE AMENDED</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Ave. 10-5-70</u> <u>Baltimore, Md. 21224</u> <u>Baltimore City Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1626 Lyle Court</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/09</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONFECTIONARY</u>	9. AGE (in years last birthday) <u>60</u>
11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACQUES SARTORI</u>		14. MOTHER'S MAIDEN NAME <u>Mary MARTINI</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>098-07-8617</u>	
17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>		ADDRESS <u>4940 Eastern Avenue</u>	
18. <u>789.01</u>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Hypernephroma i metastasis to</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Lung + brain ; 2° pneumonia</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX]	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> <u>1969</u> to <u>3/23</u> <u>1970</u> and that (I) (we) last saw the deceased alive on <u>3/23</u> <u>1970</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>C. Krush</u>		23B. DATE SIGNED <u>3/23</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. Krush, M.D.</u>		23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Ave., Balto. Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3/26/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE MEMORIAL</u>	24D. LOCATION (City, town, or county) (State) <u>DORSEY Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 26 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Frank P. [Signature]</u>	ADDRESS <u>[Signature]</u>

Certificate of Baptism from Paris, France

10-5-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

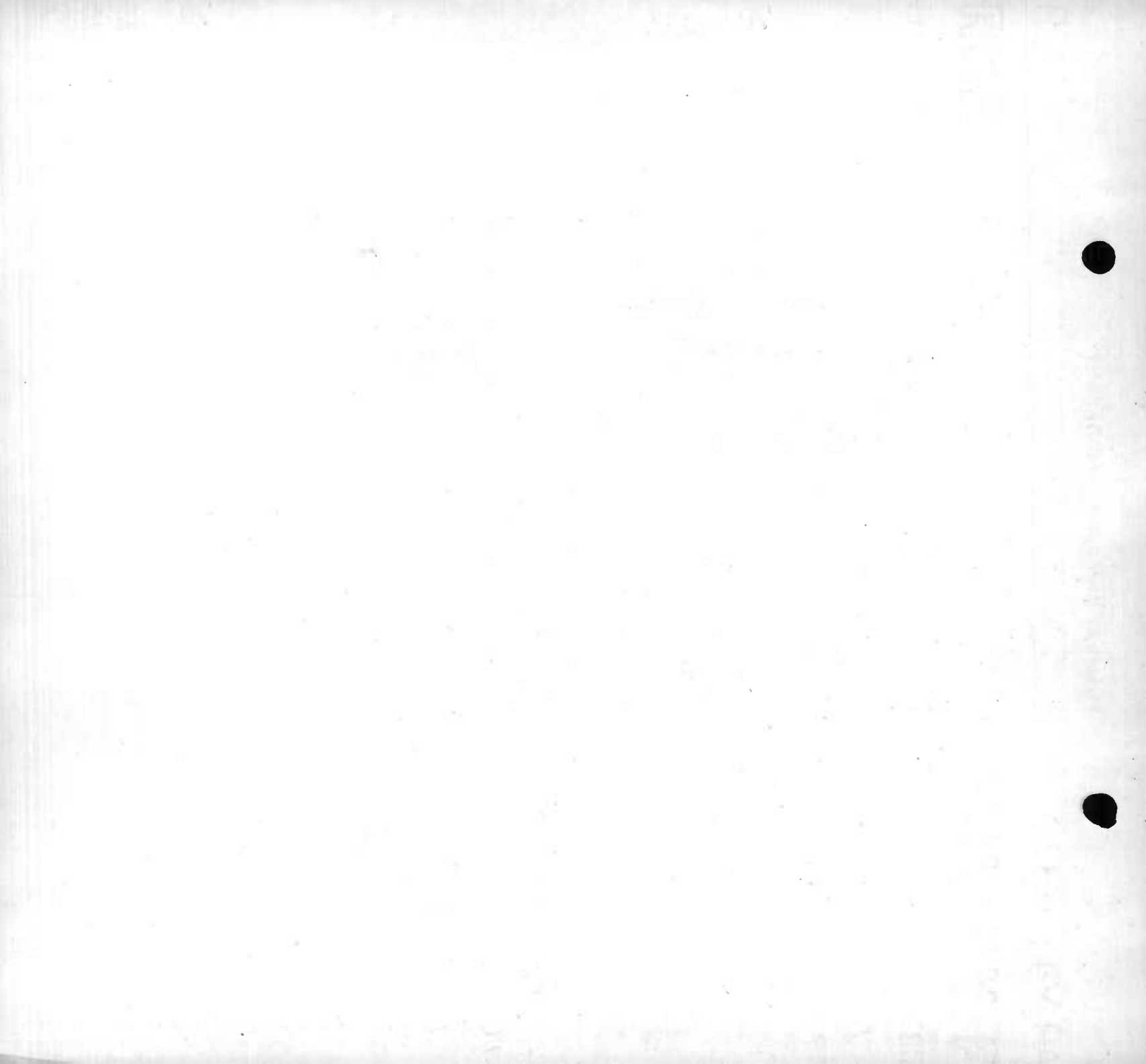
G-652		70 3228		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3228	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PIOTR GRONOSTAJSKI</b>				2. DATE AND HOUR OF DEATH <b>3-27-70 17 30</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hosp.</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE <b>Maryland</b> B. COUNTY <b>202</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hosp.</b>						C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <b>205 South Reister Street</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 1882 14</b>		9. AGE (in years last birthday) <b>87</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>TAILOR</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RETIRED</b> <b>NOT KNOWN</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>				16. SOCIAL SECURITY NO. <b>214-03-3119</b>		17. INFORMANT ADDRESS <b>A. LIPKA 3336 E. BALTO. ST. 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>acute pulmonary edema</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
						(B) DUE TO, OR AS A CONSEQUENCE OF:			
						(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-27</b> 19 <b>70</b> to <b>3-27</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-27</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>EVERNER MEYER MD</b>						23B. DATE SIGNED <b>3-27-70</b>		23C. PHYSICIAN'S NAME (Type) <b>EVERNER MEYER MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-30-70</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY CROSS CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>W. FIALKOWSKI</b>		25D. ADDRESS <b>2007 EASTERN AVE</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 70 3229				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3229	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Williams, Martha</b>				2. DATE AND HOUR OF DEATH <b>12:40 PM 3/26/70 12:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN Hosp. 930 Ashburton St. Baltimore, Md. 21216</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1205 W. LANVALE ST.</b>							
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01-01-98</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Haywood BATTLE</b>				14. MOTHER'S MAIDEN NAME <b>DELLA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. MARY MARYLAND.</b>		ADDRESS <b>daugh. (same)</b>	
18. <b>590.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>UREAMIA.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>KIDNEY FAILURE.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PYELONEPHRITIS, RECTOVAGINAL FISTULA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>—</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> 19 <b>70</b> to <b>3-26</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>3-26</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rajinder P. Gandhi</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RATINDER P. GANDHI</b>				23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/31/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT AUGUST</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Hughes 635 D GLENVIEW ST</b>		ADDRESS	

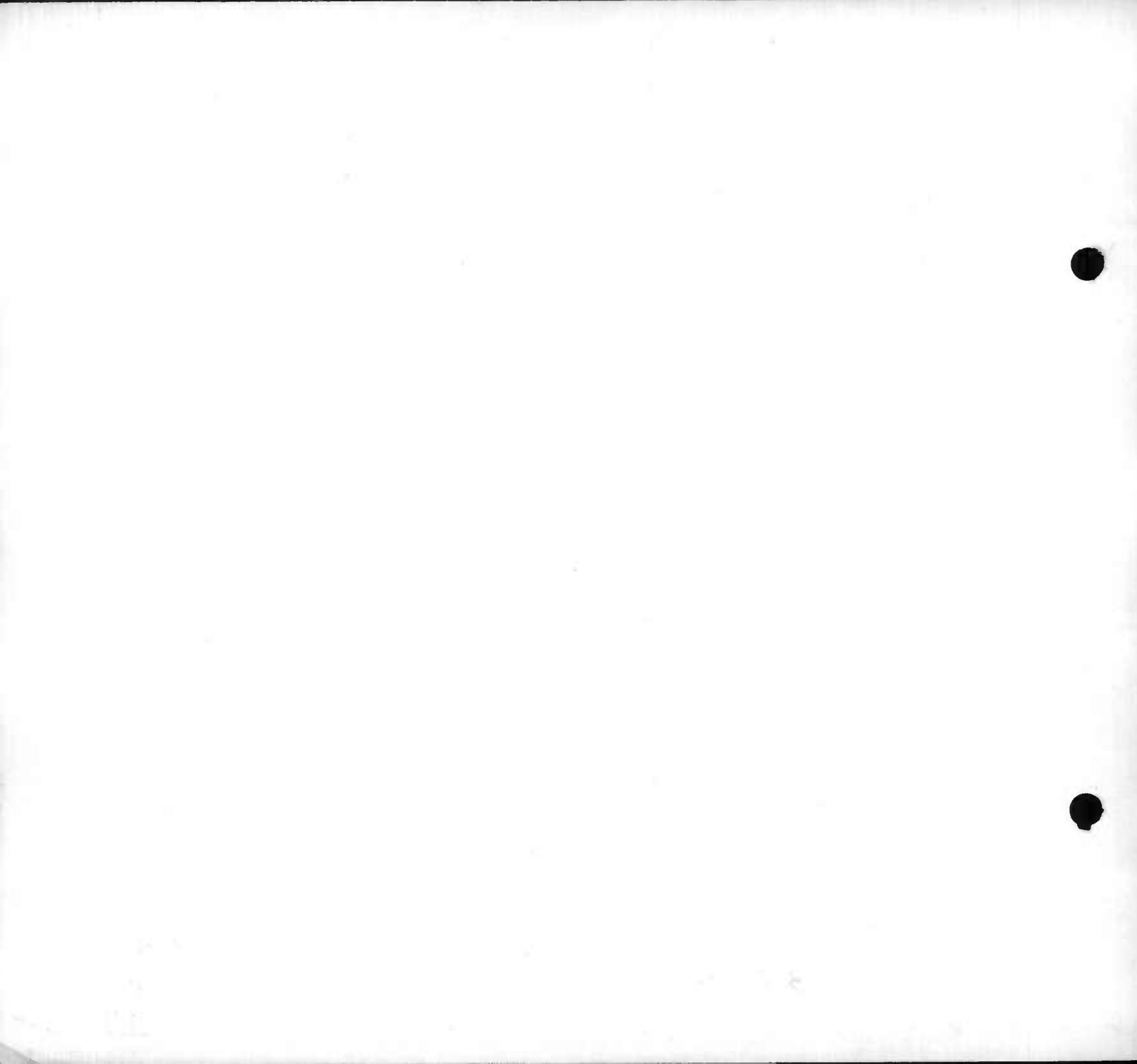




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

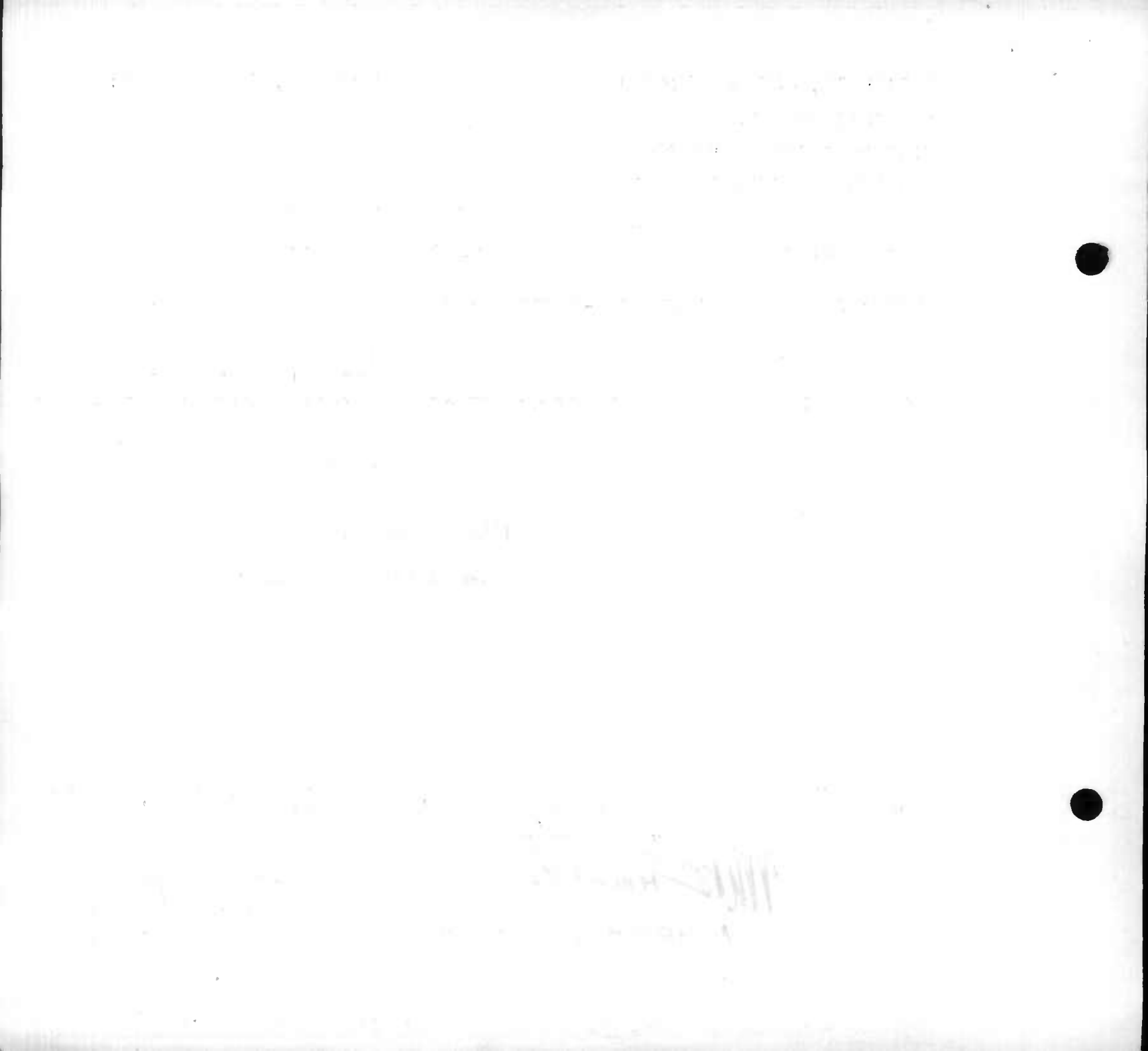
E-363 70 3230		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3230	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <u>MR. DARE EDWARDS</u>		2. DATE AND HOUR OF DEATH <u>MARCH 21, 1970</u> <u>1:15 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>CHURCH HOME AND HOSPITAL</u> <u>35</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>602</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2526 E. FAYETTE ST</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-03</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>		13. FATHER'S NAME <u>SAM EDWARDS</u>		14. MOTHER'S MAIDEN NAME <u>SALLY JONES</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>492X</u> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>EMPHYSEMA</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC LUNG DISEASE</u> <u>CONGESTIVE HEART FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>MARCH 13</u> 19 <u>70</u> to <u>MARCH 21</u> 19 <u>70</u> that <del>we</del> (we) last saw the deceased alive on <u>MARCH 21</u> 19 <u>70</u> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cezar A. Lopez MD</u>		23B. DATE SIGNED <u>March 21, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>CEZAR A. LOPEZ MD</u>	
23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>3-26-70</u>			
24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REG'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JOHNS HOPKINS MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCHD</b>					



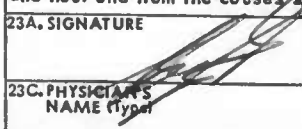
# FUNERAL DIRECTOR: IMPORTANT

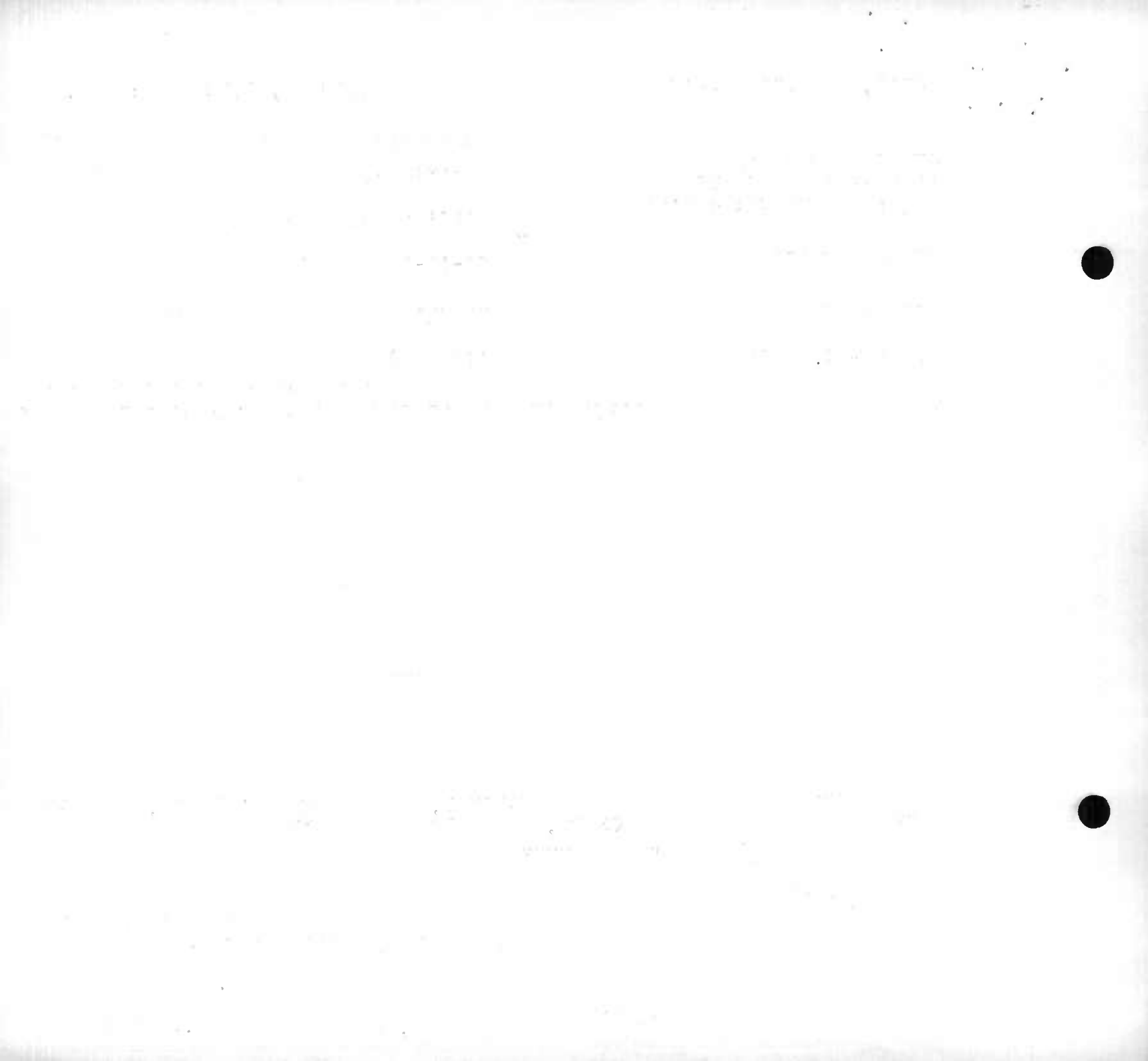
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-636 70 3231		BALTIMORE CITY HEALTH DEPARTMENT		70 3231	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>FREDERICK, RAYMOND EDWARD</b>			2. DATE AND HOUR OF DEATH <b>MARCH 27, 1970 2:30 A</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>ST AGNES HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE MARYLAND 21229</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Carroll Co</b>		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>08 21 95</b>		9. AGE (in years last birthday) <b>75</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO GAS-ELECT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Joseph Frederick</b>		
14. MOTHER'S MAIDEN NAME <b>Adelia Mannion</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW1</b>		
16. SOCIAL SECURITY NO. <b>212055762</b>			17. INFORMANT <b>RECORD IS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. CAUSE OF DEATH <b>250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pul embolus</b>					
(B) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Diabetes mellitus (Controlled)</b>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>MARCH 26, 1970</b> to <b>MARCH 27, 1970</b> that (X) (we) last saw the deceased alive on <b>MARCH 27, 1970</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. AFZAL</b>				23B. DATE SIGNED <b>3/27/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. AFZAL</b>				23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>			

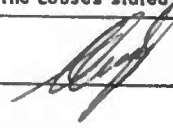


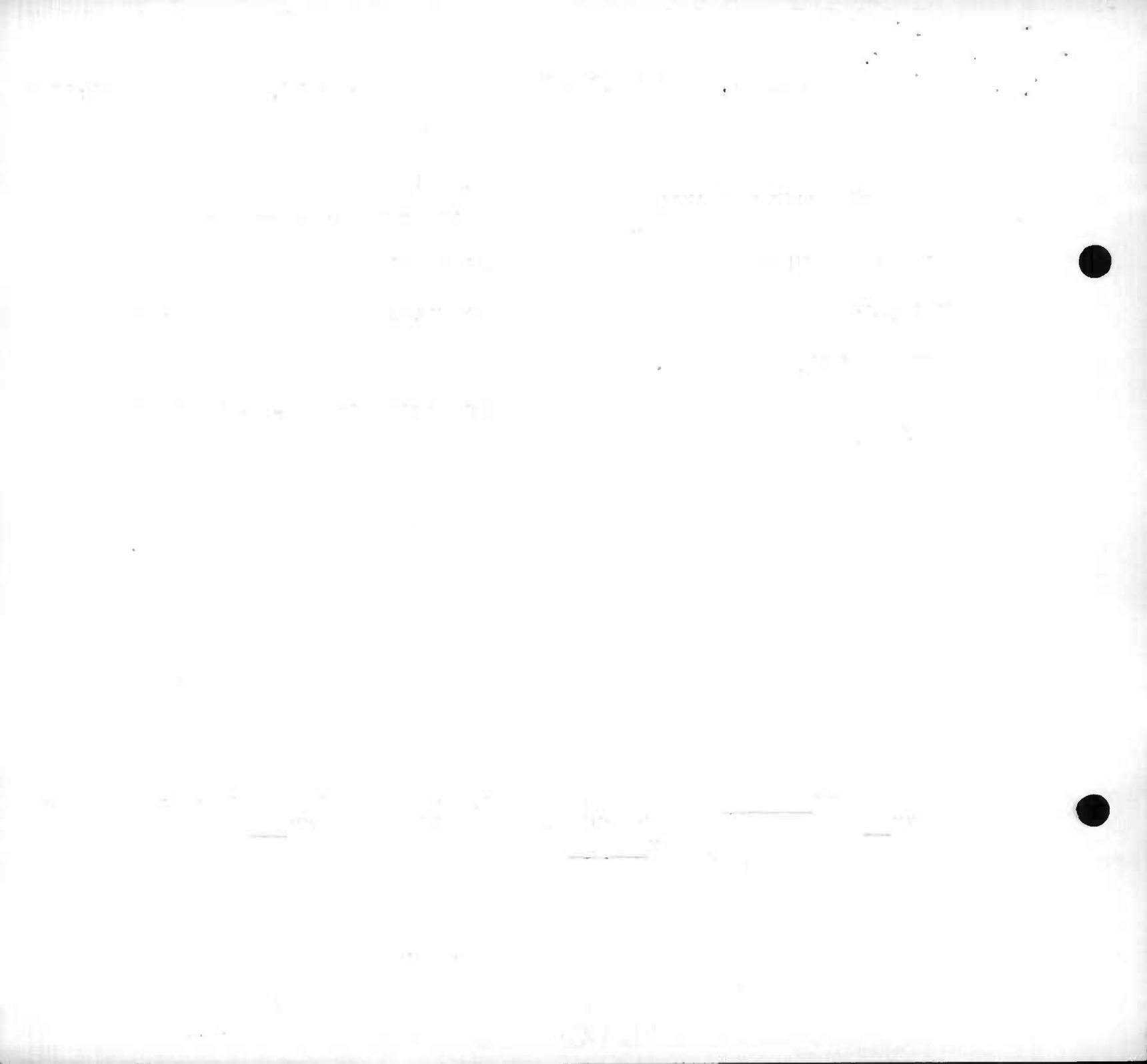
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3232		BALTIMORE CITY HEALTH DEPARTMENT		70 3232	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>PREIS, PATRICIA MARIE</b>			2. DATE AND HOUR OF DEATH <b>MARCH 26, 1970 3:50 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVENUES BALTIMORE MARYLAND 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1331 MIDDLEFORD ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>05-13-48</b>	9. AGE (In years last birthday) <b>21</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM J. PREIS</b>			14. MOTHER'S MAIDEN NAME <b>(GORMAN) Aimee</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212549147</b>	17. INFORMANT ADDRESS <b>RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Fatal Pneumonia - Bronchiectasis</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Emphysema -</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Asthmatic Bronchitis -</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>MARCH 7, 1970</b> to <b>MARCH 26, 1970</b> that (X) (we) lost saw the deceased alive on <b>MARCH 26, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>
23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			23E. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave., 21228</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. ...</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-455 70 3233		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3233	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>SELLMAN, EDNA MARGARET</b>			2. DATE AND HOUR OF DEATH <b>MARCH 25, 1970 11:35 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2005</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2429 CHRISTIAN STREET</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01 10 01</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOSEPH NAGEL</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST AGNES RECORDS-BALTO MD 21229</b>	
18. <b>451.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Thrombo-phlebitis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Congestive Heart Failure -</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>MARCH 19</b> 19 <b>70</b> to <b>MARCH 25</b> 19 <b>70</b> that <del>(X)</del> (we) last saw the deceased alive on <b>MARCH 25</b> 19 <b>70</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Robert E. Faber, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Ave., 21229</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					

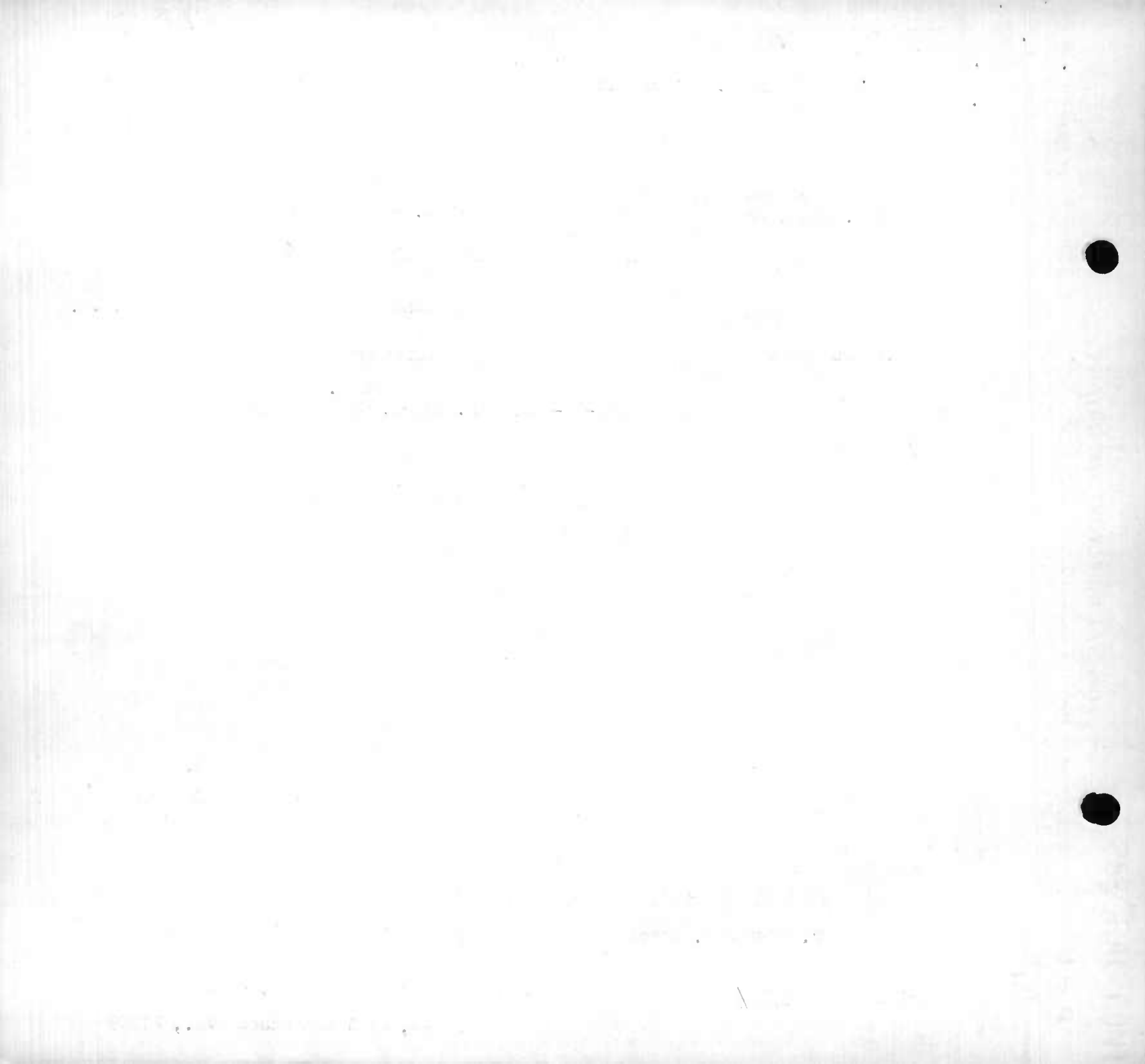




# FUNERAL DIRECTOR: IMPORTANT

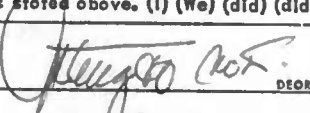
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3234</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">H-415</span>		<span style="font-size: 1.5em;">70 3234</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Ella L. Helfenbein</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/26/70</span> <span style="float: right;">5:50 a M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">70 General German Aged Home</span> <span style="font-size: 1.2em;">22 S. Athol Avenue</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">2834</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">22 S. Athol Avenue</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">6/20/1883</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">August Gesse</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Elizabeth</span>		<b>9. AGE</b> (In years lost birth day) <span style="font-size: 1.2em;">86</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-12-2605</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Tyler, General German Home</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">22 S. Athol Avenue</span>	
<b>18. CAUSE OF DEATH</b> <span style="font-size: 1.5em;">412.4 I</span> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">ARTERIOSECTOMY</span> <span style="font-size: 1.2em;">DUE TO, OR AS A CONSEQUENCE OF,</span> <span style="font-size: 1.5em;">CARDIOVASCULAR Disease</span>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">9 yrs +</span>		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">D</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">1961</span> <b>to</b> <span style="font-size: 1.2em;">3/26</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">3/28</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Phvs E O Roach M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/26/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. Thomas E. Roach</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">5550 Baltimore National Pike</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/28/70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Moreland Memorial Cemetery</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Witzke, 4101 Edmondson Ave., 21229</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-236 70 3235		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3235	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Foster, Howard</b>		2. DATE AND HOUR OF DEATH <b>3-26-70 6:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1605</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Divison Street</b> <b>Baltimore, Maryland 21217</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2520 Harlem Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-17-14</b>	9. AGE (in years last birthday) <b>55</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Portet-University Apt. Houses</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Frank Foster</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-2798</b>		17. INFORMANT <b>Mrs. Kate Leighton-Sis.</b> ADDRESS <b>Same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-13-70</b> 19 to <b>3-26-70</b> 19 that (I) (we) last saw the deceased alive on <b>3-26-70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>March 26, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>G. TENECO MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
24D. LOCATION <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
B-650 70 3236		CERTIFICATE OF DEATH		70 3236	
1. NAME OF DECEASED (Type or Print) <b>Brown, Catherine</b>			2. DATE AND HOUR OF DEATH <b>3-26-70 5:50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital 1514 Divison Street Baltimore, Maryland 21217</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1303</b>		
5. SEX <b>Female</b>			6. RACE <b>Negro</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>11-24-05</b>		
9. AGE (In years last birthday) <b>64</b>			10. UNDER 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Love Jones</b>			14. MOTHER'S MAIDEN NAME <b>Geneva Campbell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-20-0415A</b>		
17. INFORMANT <b>M's Lillian Reed-Daughter</b>			ADDRESS <b>Same</b>		
18. CAUSE OF DEATH <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia + congestive heart failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension + arteriosclerosis</b> <b>cardiovascular disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b> <b>? years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-70</b> 19 to <b>3-26-70</b> 19 that (I) (we) lost the deceased on <b>3-26-70</b> 19 <b>70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elijah Saunders</b>			23B. DATE SIGNED <b>March 27, 1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>ETIJAH SAUNDERS</b>			23D. ADDRESS <b>1514 Divison Street Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/31/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION <b>5501 Frederick Rd. Baltimore MD</b>		25A. DATE REC'D. BY HEALTH DEPT. <b>MAR 30 1970</b>			
25B. NAME OF REGISTRAR <b>DEAC J. B. M.</b>		25C. FUNERAL DIRECTOR <b>Margaretta E. Brown 3106 Walbrook Ave.</b>			

Burial

3/21/70

Baltimore National Cem. 5501 Frederick Rd. Baltimore MD

Margaretta B. Brown 3106 Walbrook Ave.

No

212-20-0412A

Love Jones

Geneva Campbell

Houswife

Separated

herine

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3237</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-625</span>		<span style="font-size: 1.5em;">70 3237</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <span style="font-size: 1.2em;">DLEVANTE MORICONI</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">March 26, 1970 3:55 AM</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">-----</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">4322 Walther Avenue 21214</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span> <b>6. RACE</b> <span style="font-size: 1.2em;">Caucasian</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Jan 27, 1894</span> <b>9. AGE</b> (in years last birthday) <span style="font-size: 1.2em;">76</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Contractor</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Utilities</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Italy</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Dominic Moriconi</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Maria Grace (unknown)</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No -----</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-03-3994</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Lee Moriconi 2228 Pelham Ave 2113</span>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small>  <b>ANTECEDENT CAUSES</b>  <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="width: 15%; text-align: center;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div> <div style="margin-top: 10px;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Progressive heart failure</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B)</b> <span style="font-size: 1.2em;">Myocardial infarction</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C)</b> <span style="font-size: 1.2em;">arteriosclerotic cardiovascular D.</span> </div> <div style="margin-top: 10px;"> <b>II</b>  <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>  <span style="font-size: 1.2em;">Diabetes Mellitus - Pneumonia</span> </div>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">NO</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examined) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/28</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/26</span> 19 <span style="font-size: 1.2em;">70</span></b> <b>that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Manuela M. Ribeiro, MD.</span>				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MANUELA M. RIBEIRO, MD.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Mercy Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">Mar 30, 70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 20 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">J. E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Dippel Bro's Inc. 7110 Belair Rd.</span>			

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11/28 325

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.	
R-254 70 3238		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RISSMILLER, Lillian		March 26, 1970 10:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 Bolton Hill Nursing & Convalescent Ctr.			A. STATE Maryland		
			B. COUNTY Baltimore		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			4420 Annapolis Road 21227		
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-99	9. AGE (In years lost birthday) 70	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred Shoemaker		14. MOTHER'S MAIDEN NAME Eliaabeth Werkeiser	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 206-36-5205		17. INFORMANT MRS Rose Jackson, Same as Y	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.A. Pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis generalized (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1964	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/7 1969 to 3/26 1970, that (I) (we) last saw the deceased alive on 3/26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. H. Marent MD		23B. DATE SIGNED 3/27/70		23C. PHYSICIAN'S NAME (Type) ALLAN H. MARENT MD	
23D. ADDRESS 2 E Red St. Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 30 MAR 70	
24C. NAME OF CEMETERY OR CREMATORY Jehovah Luth. Ch. Cemetery		24D. LOCATION WIND GAP, PA.		25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970	
25B. NAME OF REGISTRAR B. E. Taylor		25C. FUNERAL DIRECTOR KIRKLEY Funeral Home		25D. ADDRESS Glen Burnie, MD	



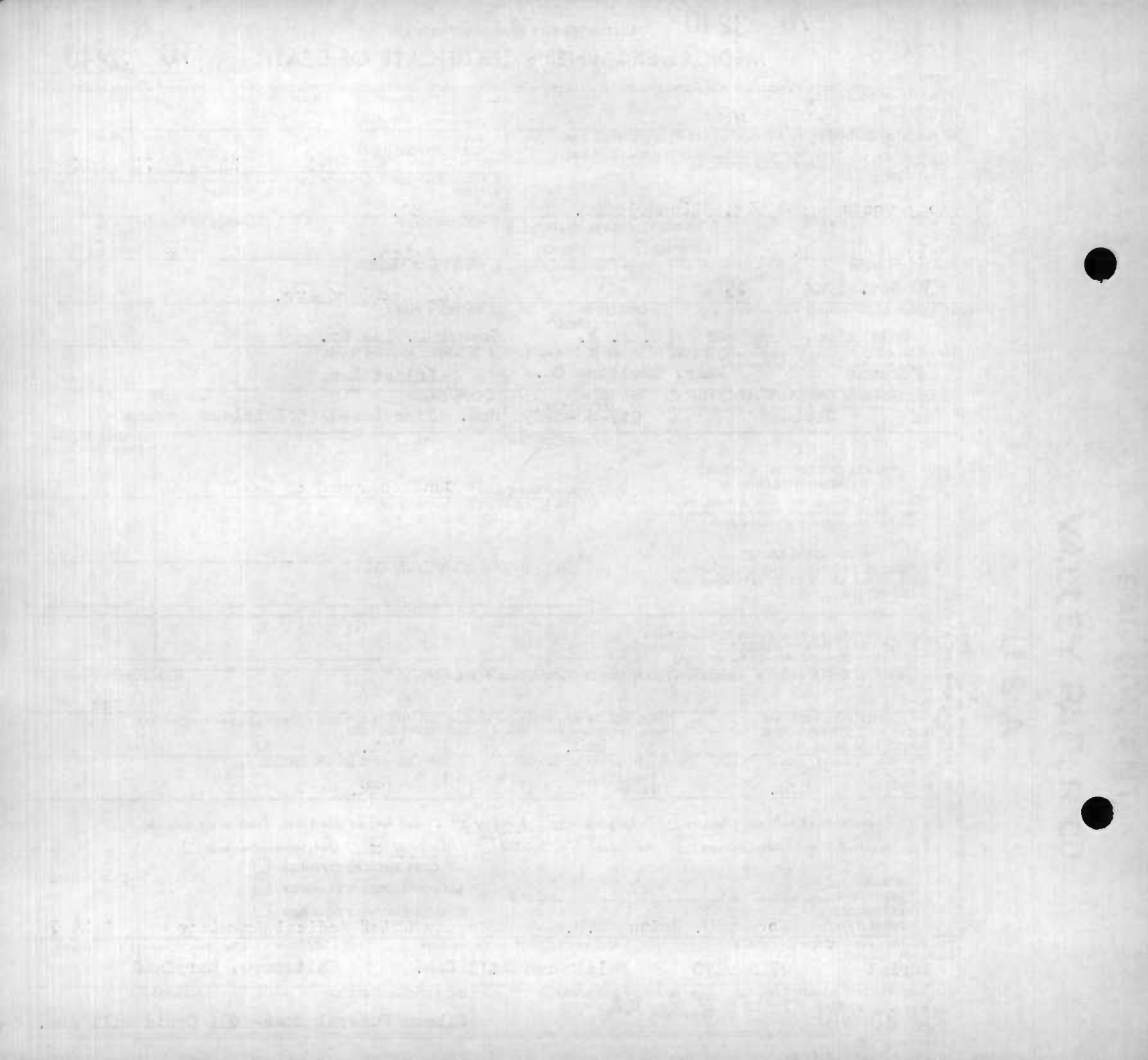
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3239	
M-200 70 3239		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>JAMES R. Mosso</b>		2. DATE AND HOUR OF DEATH 3. 25. 1970 7:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>		A. STATE <b>BALTIMORE MD</b>		B. COUNTY <b>102</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35100 N Broadway Balto MD. 21231</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12. 11. 1911</b>		9. AGE (in years last birthday) <b>58 yrs.</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service man at Bethlehem Steel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>William Mosso</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE MALONE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>283-05-1089</b>		17. INFORMANT <b>wife Bessie W. Mosso</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ventricular Fibrillation</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arrest on ch. alcoholism # neck R. of femur</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Int.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASVD</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2908 E Balto H.</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>3-7-70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3. 9. 1970</b> to <b>3. 25. 1970</b> that (I) (we) last saw the deceased alive on <b>3. 25. 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abdus Samad MD</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ABDUS SAMAD MD</b>	
23D. ADDRESS <b>Church Home &amp; Hospital 100 N Broadway Balto MD. 21231</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-30-70</b>	
24C. NAME of CEMETERY or CREMATORY <b>RIVERVIEW CEMETERY</b>		24D. LOCATION (City, town, or county) <b>MARTINS FERRY</b>		24E. STATE <b>OHIO</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks TOWSON, INC</b>	
25D. ADDRESS <b>1050 YORK Rd TOWSON, Md.</b>					

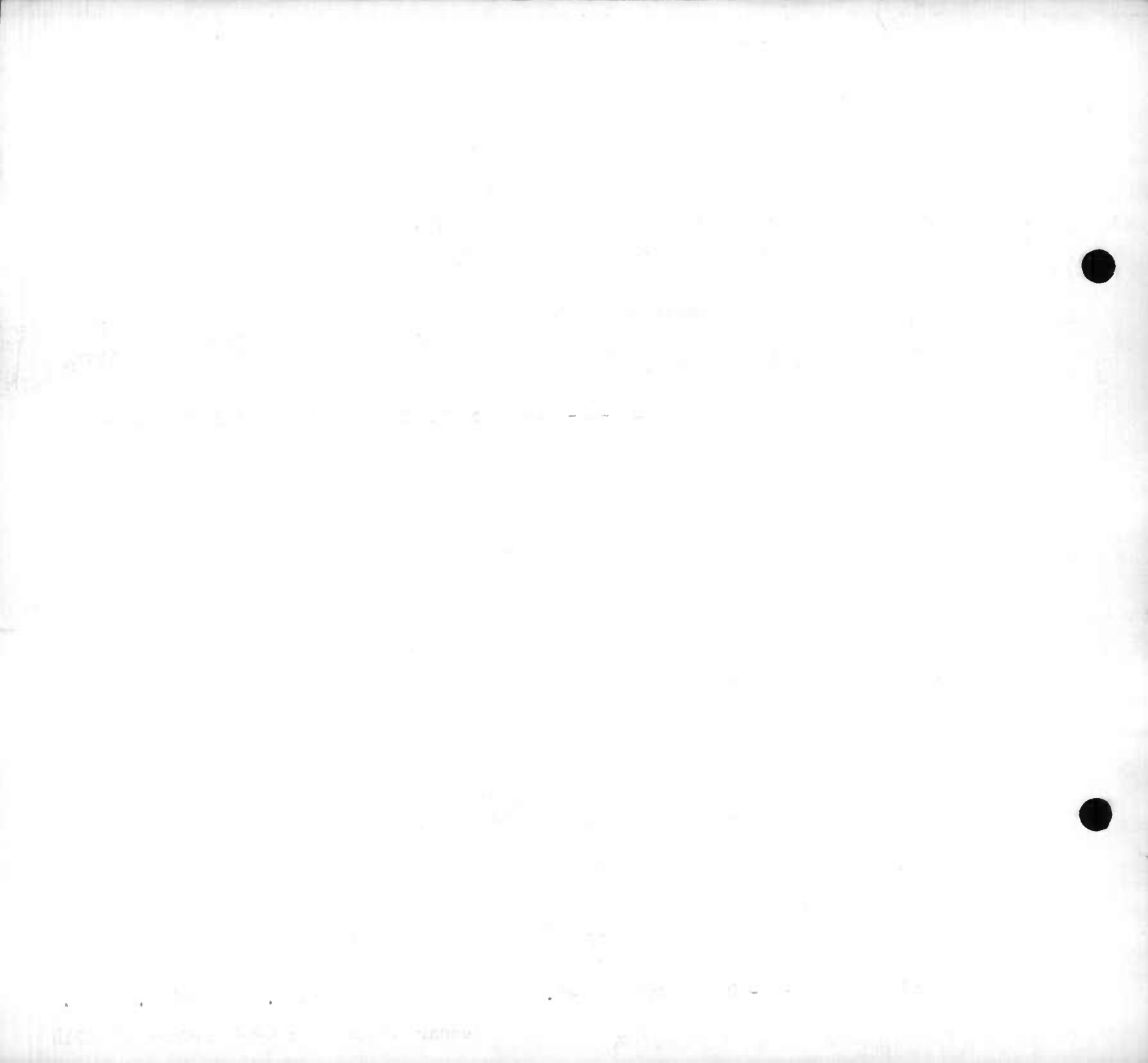
FOR OFFICIAL USE ONLY

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
JOSEPH LEE		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
Rear woods - 900 blk. Allendale St.		Md.		3 23 70 6:03 P.M.		2802			
6. SEX 7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Male Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years last birthday)		E. STREET AND NUMBER					
30 Nov. 1944		25		4415 Kathland Ave.					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
Baltimore, Maryland		U. S. A.		Joseph E. Lee Sr.					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Foreman		Amer. Smelting Co.		Luliet Lane					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
Yes Vietnam		219-40-6289		Mrs. Alice Lee		4415 Kathland Avenue			
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Gunshot wound of head					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		(B)		DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		00-00			
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
Unk.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		Unk.					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED					
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
Werner U. Spitz, M.D.		Deputy Chief Medical Examiner		3-24-70					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		27 Mar 70		Baltimore Nat'l Cem.		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 30 1970		Robert E. Taylor, M.D.		Gibson Funeral Home		1631 Druid Hill Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3241</span>	
70 3241 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Walter Kirkpatrick</u>		2. DATE AND HOUR OF DEATH <u>March 26, 1970 4:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u> <u>33rd &amp; Calvert Sts.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2745</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
15. SEX <u>Male</u>			6. DATE OF BIRTH <u>8-19-86</u>		9. AGE (In years last birthday) <u>83</u>
6. RACE <u>Caucasian</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance Agent</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Reuben M. Kirkpatrick</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth A. Kirkpatrick</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-10-9011</u>		17. INFORMANT <u>Mrs Virgie H Kirkpatrick 3032 Pinewood Ave</u>
18. <u>540.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>3-13-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>small bowel obstruction</u>		20A. AUTOPSY (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> 19 <u>70</u> to <u>Mar 26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Mar 25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Gunneth</u>			23B. DATE SIGNED <u>March 26, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>R. Gunneth</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Rueck Inc 5305 Harford Rd 21214</u>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3242</span>	
N-550 70 3242				CERTIFICATE OF DEATH	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			March 26, 1970. 8 AM M.		
GERALD A. NOONAN					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  Union Memorial Hospital-DOA.			A. STATE Md. B. COUNTY		
5. SEX Male			6. RACE Caucasian		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 11, 1902		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday) 67		
Ret. Govt. Employee			10B. KIND OF BUSINESS OR INDUSTRY Plumber		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Baltimore, Maryland			U.S.A.		
13. FATHER'S NAME Patrick Noonan			14. MOTHER'S MAIDEN NAME Mary H. Barrett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-16-8669		
17. INFORMANT Paul Noonan			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH I 410.0 Disease or condition directly leading to death  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (C) DUE TO, OR AS A CONSEQUENCE OF: Coronary Vascular Rerod disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. July 1965					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Feb 27, 1971 to March 25, 1970, that (I) (we) last saw the deceased alive on March 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Michael Grossfeld M.D.			23B. DATE SIGNED 3-26-70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
5402 Belair Road Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/30/70		New Cathedral Cem.	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Balto. Md.		MAR 30 1970		Robert E. Taylor M.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS			
Leonard J. Ruck Inc. Balto. Md.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-532 70 3243		BALTIMORE CITY HEALTH DEPARTMENT		70 3243	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>KATHERINE A. NIEMITZ</b>			2. DATE AND HOUR OF DEATH <b>03-26-70 12.20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>			A. STATE <b>MARYLAND . U.S.A</b>		B. COUNTY <b>2731</b>
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>4223 HARCOURT ROAD</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>06-20-86</b>	9. AGE (In years last birthday) <b>83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>
13. FATHER'S NAME <b>UNKNOWN Kamke</b>			14. MOTHER'S MAIDEN NAME <b>MARY KAMKE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-9230D</b>		17. INFORMANT <b>Miss Edna Niemitz</b> <b>12000000000000000000</b>	
				ADDRESS <b>SAME AS ABOVE</b>	
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenoia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO RESPIRATORY ARREST.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) CHRONIC CONGESTIVE DISEASE</b> <b>(C) HYPERTENSIVE CARDIOVASCULAR</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>02-07-1970</b> to <b>03-26-1970</b> that (I) (we) last saw the deceased alive on <b>03-26-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Yasumasa Yamasaki M.D.</b>				23B. DATE SIGNED <b>MARCH-26-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>YASUMASA YAMASAKI M.D.</b>				23D. ADDRESS <b>33RD AND CALVERT STREETS BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck I c. Baltimore, Maryland</b>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70 3244</b></p>	
<p>BIRTH NO. <b>0-540</b></p>		<p>DATE AND HOUR OF DEATH <b>3/26/70 4:35 P. M.</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>MARGARET O'NEILL</b></p>		<p>2. DATE AND HOUR OF DEATH <b>3/26/70 4:35 P. M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <b>7 Mercy Hospital</b></p>		<p>A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b></p>	
<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>3022 Acton Rd.</b></p>		<p>F. STREET AND NUMBER <b>3022 Acton Rd.</b></p>	
<p>5. SEX <b>F</b></p>	<p>6. RACE <b>W</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>12-21-1914</b> 9. AGE (in years last birthday) <b>55</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>Martin F Dunphy</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Winifred Durken</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <b>Mr John J O'Neill</b></p>		<p>ADDRESS <b>Same</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p>		<p>CAUSE OF DEATH</p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio-sclerotic Heart Disease</b></p>	
<p>ANTECEDENT CAUSES</p>		<p>(B) <b>Cerebral Vascular Sclerosis</b> - 1 yr.</p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C) <b>Generalized Arterio-sclerosis</b></p>	
<p>19. DATE OF OPERATION</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>21G. HOW DID INJURY OCCUR?</p>		<p>21H. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> 19 <b>70</b> to <b>3/26</b> 19 <b>70</b></p>		<p>that (I) (we) last saw the deceased alive on <b>3/26/70</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <b>Earl L. Chambers M.D.</b></p>		<p>23B. DATE SIGNED <b>3/26/70</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers M.D.</b></p>		<p>23D. ADDRESS <b>100 - W. Cold Spring - Balto - Md.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>3/31/70</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b></p>		<p>25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b></p>		<p>ADDRESS <b>Baltimore, Maryland</b></p>	

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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 70 3245

1. NAME OF DECEASED (Type or Print) <p align="center"><b>GEORGE TREBES</b></p>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 25 70 1:40 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <p align="center">00 1002 Bristol Place</p>		3. DATE PRONOUNCED DEAD Month Day Year Hour <p align="center">March 25, 1970 1:40 p. M.</p>	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Feb. 25, 1897		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker		14B. KIND OF BUSINESS OR INDUSTRY John Pradel & Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. II		17. SOCIAL SECURITY NO. 218-14-8243	
15. MOTHER'S MAIDEN NAME Mary R. Bissert		18. INFORMANT Mary Trebes	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <p align="center">412.44 185X</p>		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II Carcinoma of the prostate		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/70	
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hgw. Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME		ADDRESS 12163 Charles St.	

ACADEMY OF EMERITUS



FUNERAL DIRECTOR: IMPORTANT  
MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

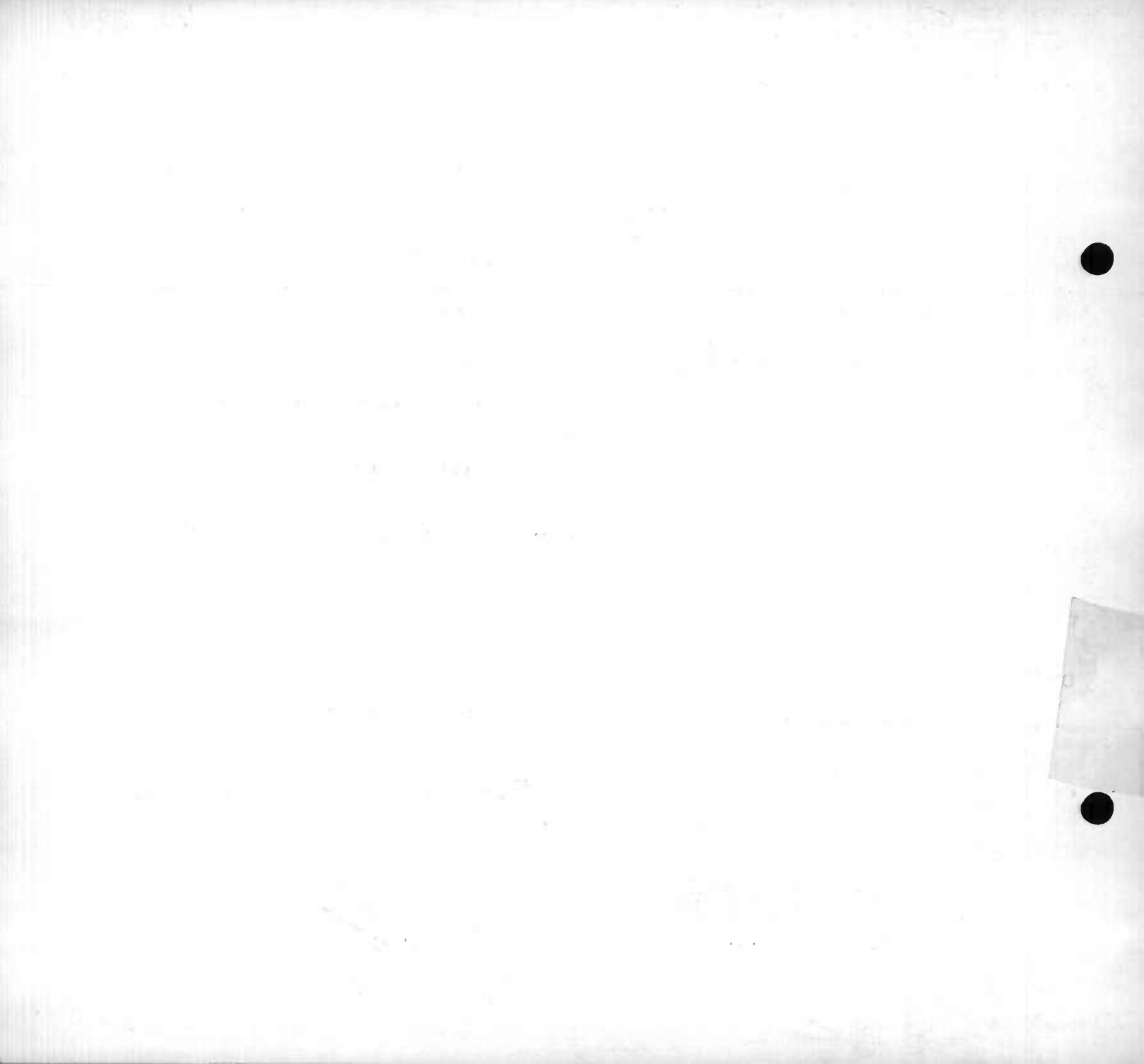
N-620 70 3246		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3246	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Norwicz, Gerald P.</u>			2. DATE AND HOUR OF DEATH <u>March 28, 1970 8:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33 BALTIMORE, MD 21205</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u>			6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCKBROKER</u>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>10-27-34</u>
13. FATHER'S NAME <u>FRANK NORWICZ</u>			14. MOTHER'S MAIDEN NAME <u>IDA KAPELANCZYK</u>		9. AGE (in years last birthday) <u>35</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>215-30-9813</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
17. INFORMANT <u>DORIS NORWICZ</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
18. <u>397.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrhythmia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Rheumatic Valvular dis.</u>			(B) <u>20 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>this hospital</u> attended the deceased from <u>19 58</u> to <u>19 70</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas R. Griggs MD</u>			23B. DATE SIGNED <u>May 28, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>THOMAS R. GRIGGS</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>3/31/70</u>		24C. NAME of CEMETERY or CREMATORY <u>DULANEY VALLEY GAR.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>			25B. NAME OF REGISTRAR <u>John H. Weber</u>		25C. FUNERAL DIRECTOR <u>JOHN H. WEBER &amp; SONS INC</u>
24D. LOCATION (City, town, or county) (State) <u>MD.</u>			25D. ADDRESS <u>401 S CHESTER ST.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

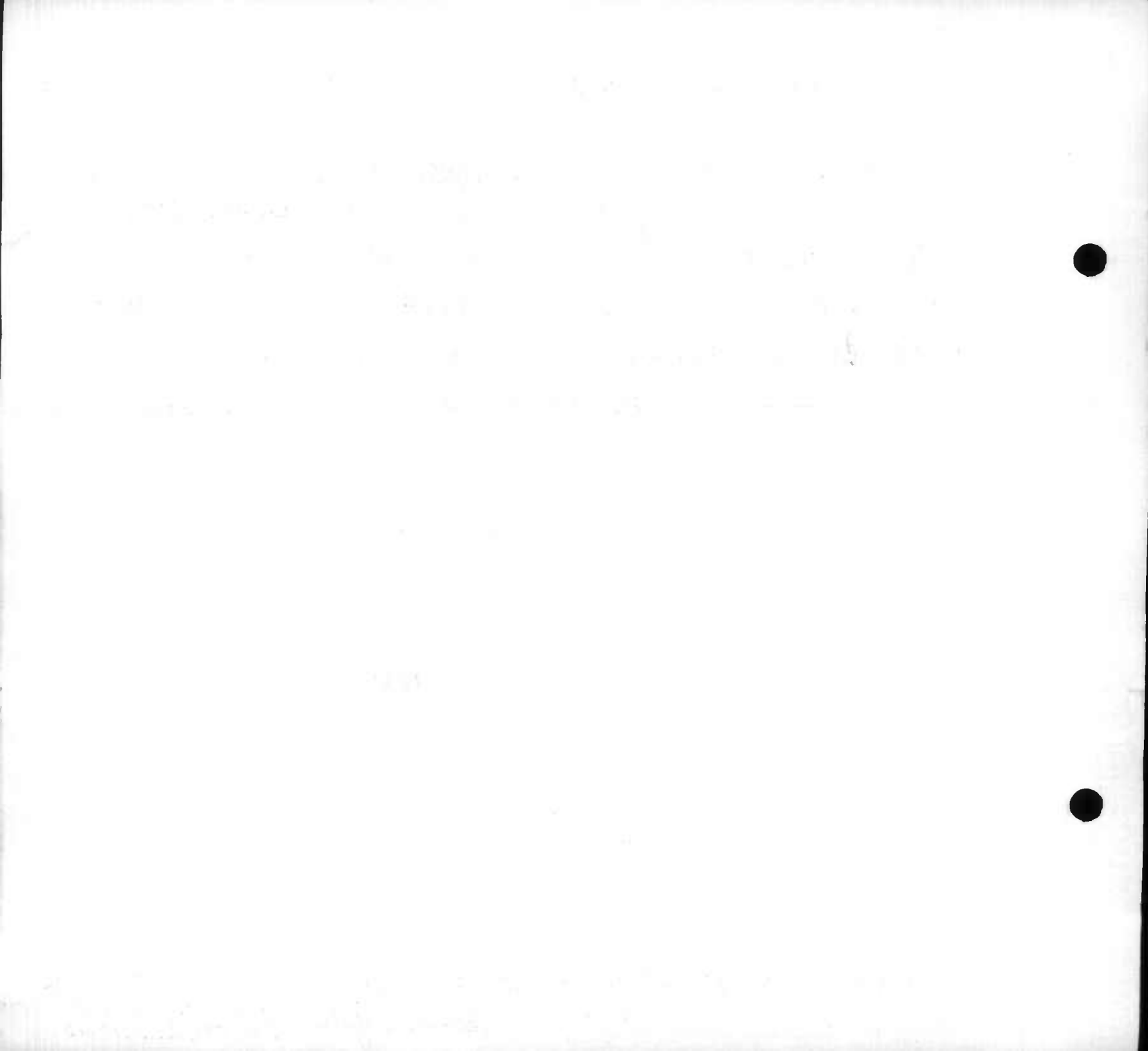
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3247</span>	
<div style="display: flex; justify-content: space-between; align-items: center;"> <span style="font-size: 2em;">S-262 70 3247</span> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Anna C. SIKORSKI</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MARCH 25, 1970</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">00 1421 S. HANOVER ST.</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		
			E. STREET AND NUMBER <span style="font-size: 1.2em;">1421 S. Hanover St.</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">JAN 24, 1914</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Joseph MADEJ</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Julia -</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.	17. INFORMANT <span style="font-size: 1.2em;">Mrs Helen Puhanskas - 1421 S. Hanover ST</span>		
18. <span style="font-size: 1.5em;">4122 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(A) IMMEDIATE CAUSE Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF:		Immediate
			(B) Hypertensive cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF:		1 year
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 15, 1969</span> 19 to <span style="font-size: 1.2em;">March 25, 1970</span> 19, that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">March 7, 1970</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Harry Deibel M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3/26/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Harry Deibel M.D.</span>			23D. ADDRESS <span style="font-size: 1.2em;">1226 S. Hanover Street</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">3-28-70</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Cross Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland 21225</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 30 1970</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">John H. Hahn</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John H. Hahn</span>		ADDRESS <span style="font-size: 1.2em;">4200 PENNINGTON AVE</span>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

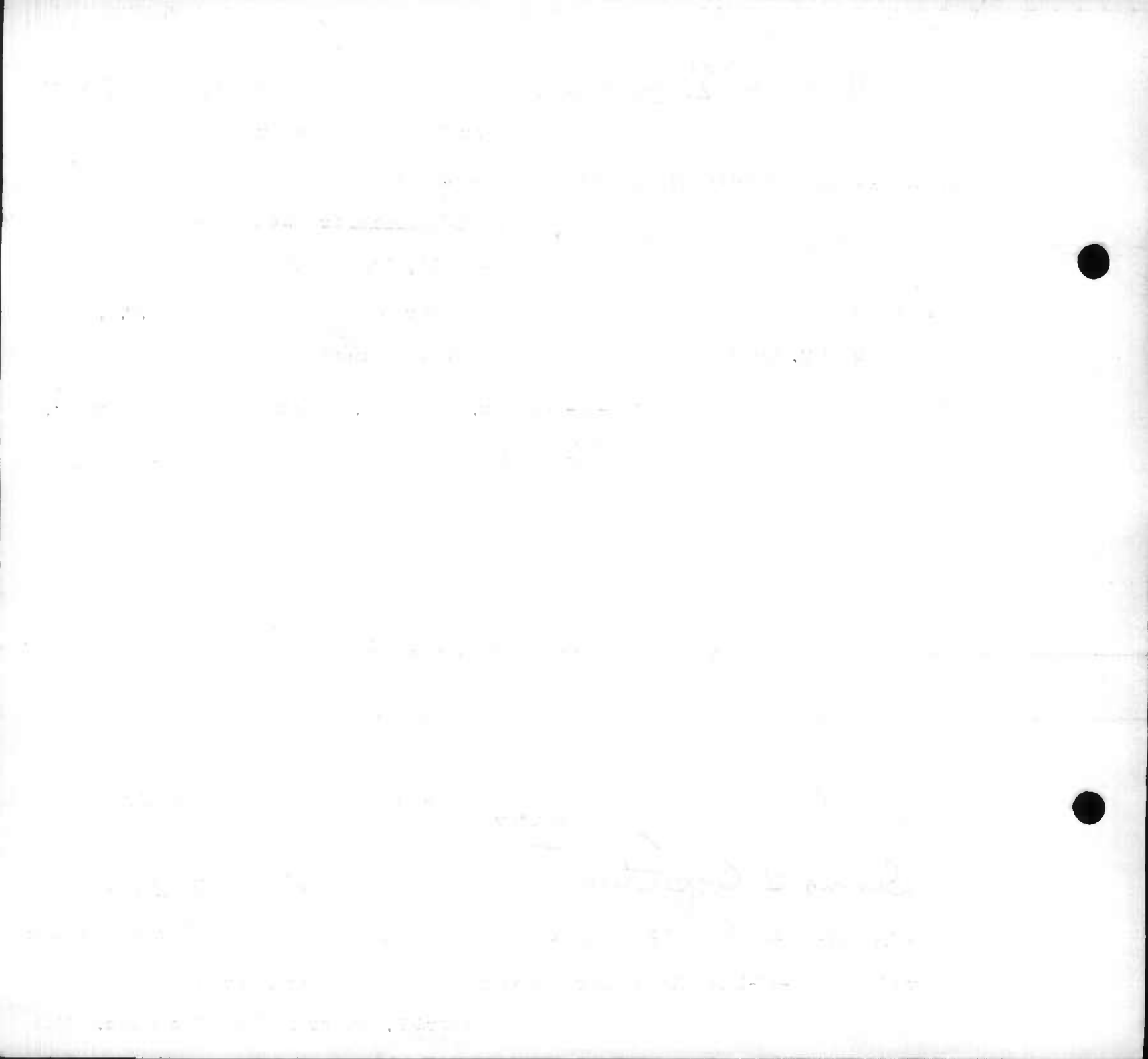
F-620		70 3248		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3248	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RUTH MARY Fries</b>				2. DATE AND HOUR OF DEATH <b>26 March 70 3:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt. C</b>		53-00			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b> 38				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>LANSDOWNE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-8-22</b>		9. AGE (In years last birthday) <b>47</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LLOYD POLING</b>				14. MOTHER'S MAIDEN NAME <b>ETHEL CAMPBELL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>235-34-6100</b>		17. INFORMANT <b>JAMES L. FRIES</b>			
				ADDRESS <b>130 5TH ST. BALTO. 21227 MD.</b>					
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>161.9 I</b>					(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					(B) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <b>CARCINOMA OF LARYNX</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>D</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <b>he</b> (this hospital) attended the deceased from <b>3/24/70</b> 19 to <b>3/26/70</b> 19 that <b>we</b> last saw the deceased alive on <b>3/26/70</b> 19 and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> (did not) view the body after death.									
23A. SIGNATURE <b>Dore P. Baker M.D.</b>					23B. DATE SIGNED <b>26 Mar 70</b>			23C. PHYSICIAN'S NAME (Type) <b>Dore P. BAKER M.D.</b>	
23D. ADDRESS <b>University Hospital Balt. Md.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-30-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., BA. CO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Charles E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles E. Taylor</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., 21224 MD.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3249</u>
S-616 70 3249		BIRTH NO. <u>70 3249</u>		
1. NAME OF DECEASED (Type or Print) <u>Lowman VIRGINIA L. SERVARY</u>		2. DATE AND HOUR OF DEATH <u>3-24-70 900 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO STATE HOSPITAL</u> <u>91</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> <u>C</u> <u>63-00</u> C. CITY OR TOWN <u>Elkridge</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1319 Montgomery Road</u>		
5. SEX <u>71</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1904</u>	9. AGE (in years lost birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Charles T. Lowman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-4915</u>		17. INFORMANT <u>Mr. William H. Servary, 1319 Montgomery Rd.</u>
18. <u>1929 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>GLIOBLASTOMA MULTIFORME</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>GLIOBLASTOMA MULTIFORME</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from <u>3-4 19 70</u> to <u>3-24 19 70</u> that (H) (we) lost saw the deceased alive on <u>3-24 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Irving L. Cooperstein</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-24-70</u>
23C. PHYSICIAN'S NAME (Type) <u>IRVING L. COOPERSTEIN</u>		23D. ADDRESS <u>MONTEBELLO STATE HOSP, BALTO. 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-28-1970</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>

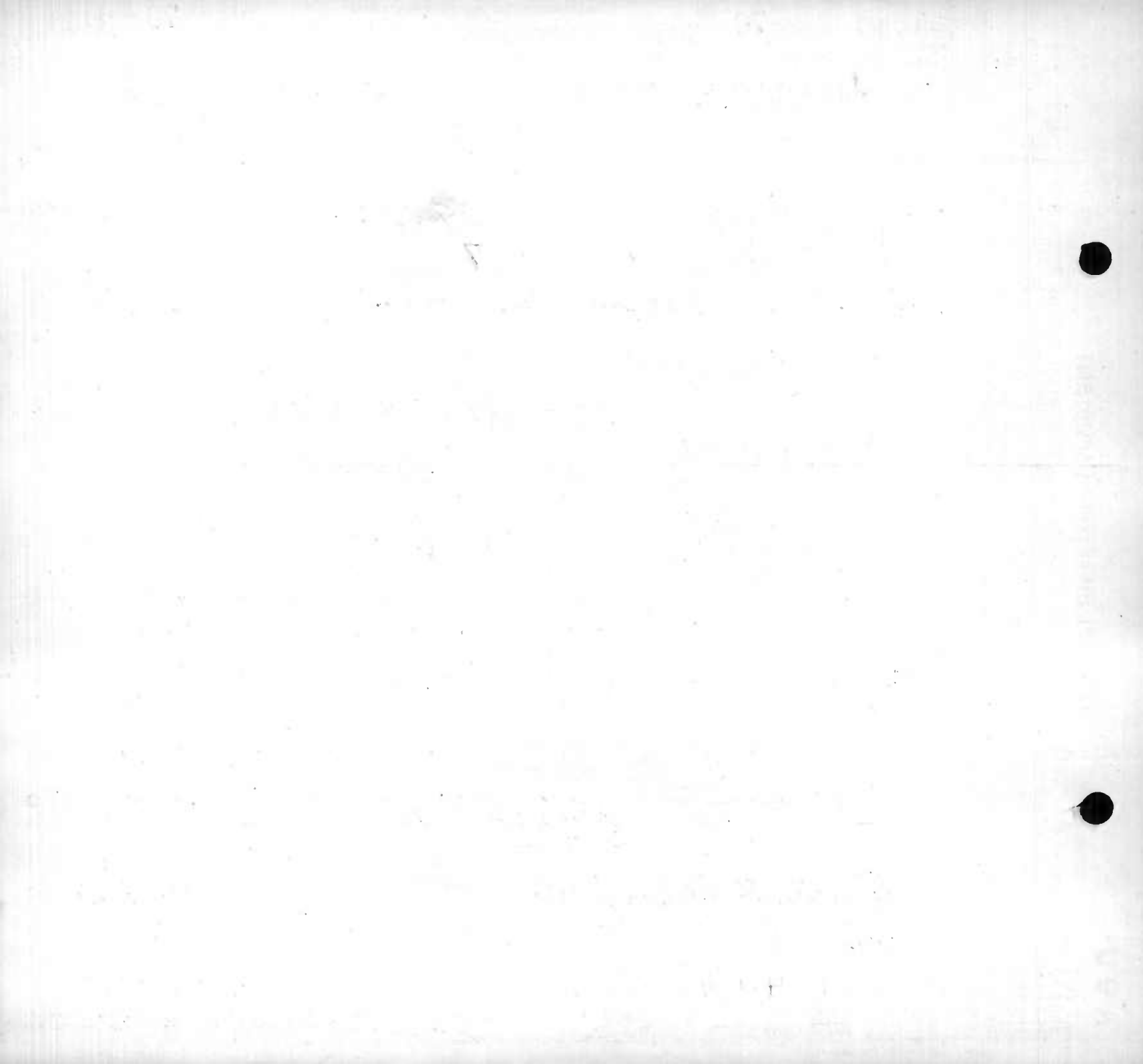




# FUNERAL DIRECTOR: IMPORTANT

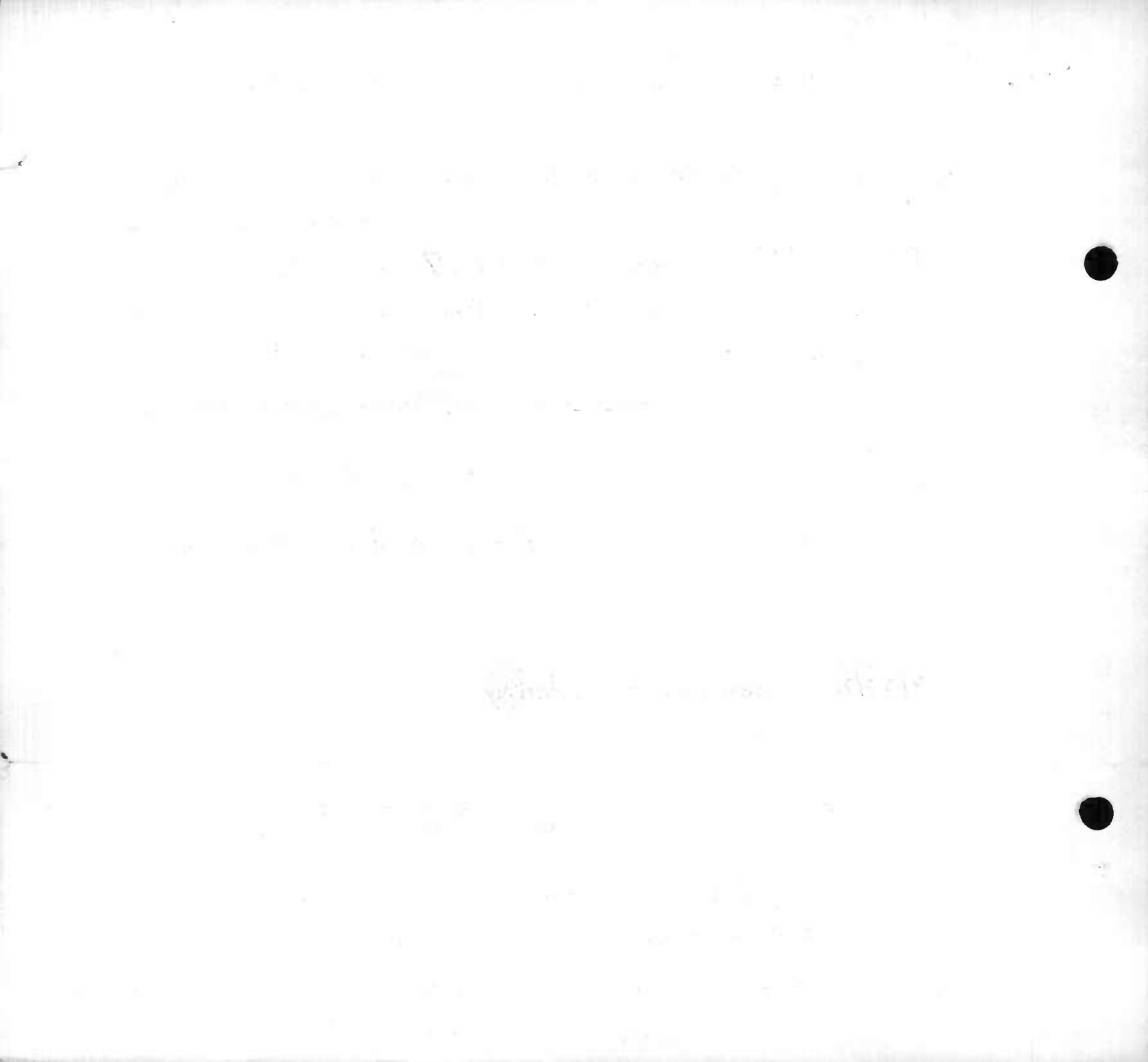
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 70 3250				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3250	
1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE HALL</b>				2. DATE AND HOUR OF DEATH <b>3-28-70 6:45 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 JOHN'S HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHN'S HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>COCKEYSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>29 Hollister Ave. #21030</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-01</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Convalescent Home</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT SMITH</b>				14. MOTHER'S MAIDEN NAME <b>MARTY HOWARD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>work</b>		17. INFORMANT <b>Robert H. Smith - Cockeysville, Md.</b>			
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Uremia</b>  (B) <b>Cancer of uterine cervix</b> DUE TO, OR AS A CONSEQUENCE OF: <b>11 months</b>  (C) _____			
19A. DATE OF OPERATION <b>May '69</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Cervix</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 26</b> 19 <b>70</b> to <b>March 28</b> 19 <b>70</b> . that (I) ( <del>was</del> ) last saw the deceased alive on <b>March 28</b> 19 <b>70</b> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Duncan R. Neilson, Jr. M.D.</b>				23B. DATE SIGNED <b>March 28, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>DUNCAN R. Neilson, Jr. M.D.</b>	
23D. ADDRESS <b>Johna Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>4/1/70</b>		24C. NAME OF CEMETERY or CREMATOR <b>Longfist</b>		24D. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. C. Clatman, Jr.</b>			



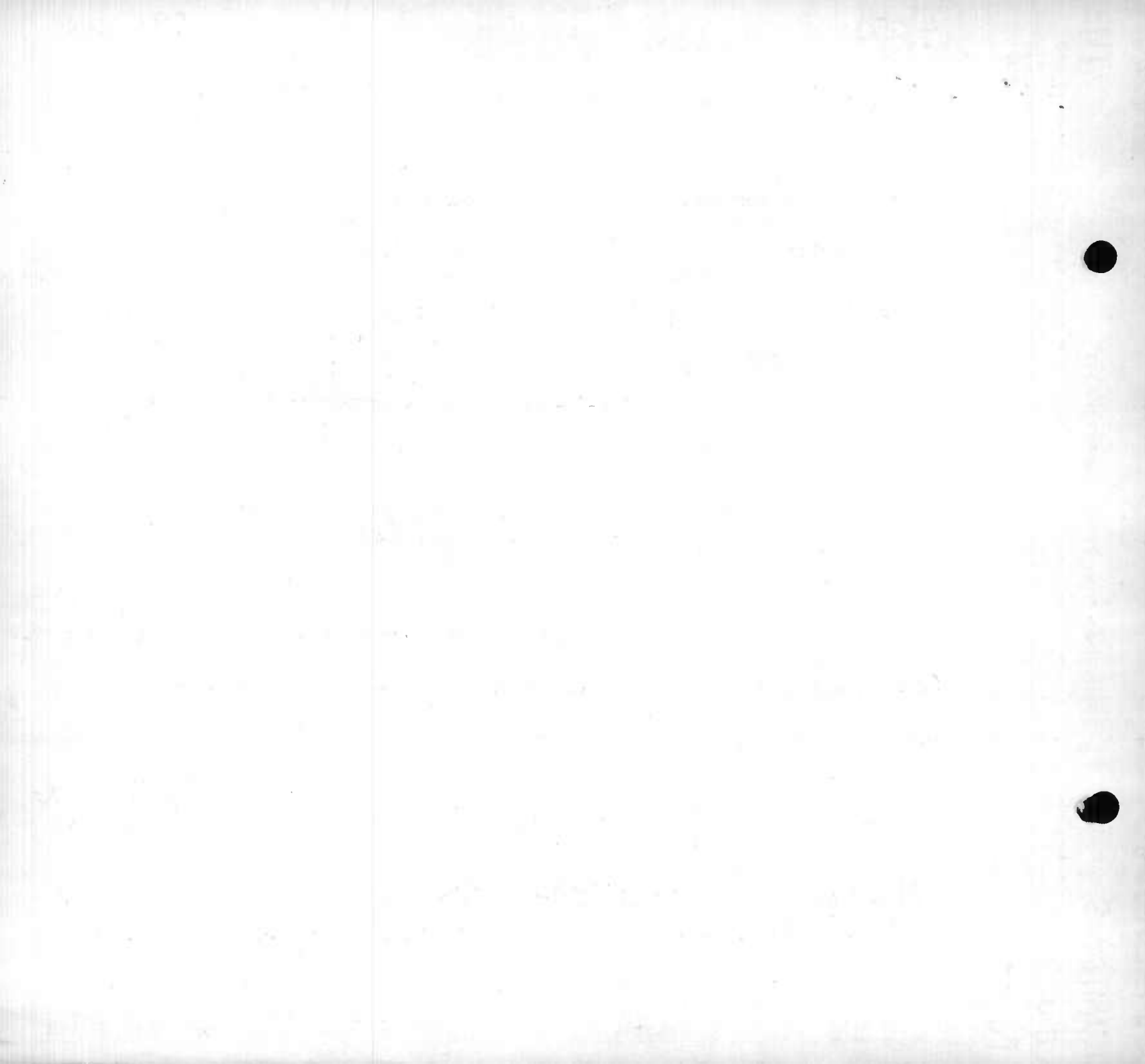
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____	
BIRTH NO. <b>3-432 70 3251</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WARREN A. SHULTZ</b>		2. DATE AND HOUR OF DEATH <b>27<sup>th</sup> MARCH 1970; 12:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2740</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE INC.</b>		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
42		E. STREET AND NUMBER <b>3416 PARKINGTON AVE. #15</b>	
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1897</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sealtest Milk Co.</b>	9. AGE (In years last birthday) <b>72</b>
13. FATHER'S NAME <b>William B. Schultz</b>		14. MOTHER'S MAIDEN NAME <b>Mollie A. Goldsmith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-2800 A</b>	
17. INFORMANT <b>Mrs. Mildred Ward</b>		ADDRESS <b>3416 Parkington Ave</b>	
18. <b>441.2. I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PROFUSE HAEMORRAGE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>RUPTURED AORTIC ANEURYSM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>3/27/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABDOMINAL AORTIC ANEURYSM</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>3-23-1970</b> to <b>3-27-1970</b> that (1) (we) last saw the deceased alive on <b>3-27-70</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>K. C. Reddy</b>		23B. DATE SIGNED <b>3/27/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR K. C. REDDY</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/31/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>WOODLAWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>J. E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>LOBING BYERS</b>		25D. ADDRESS <b>8728 LIBERTY RD. RANDALLS TOWN 21133</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

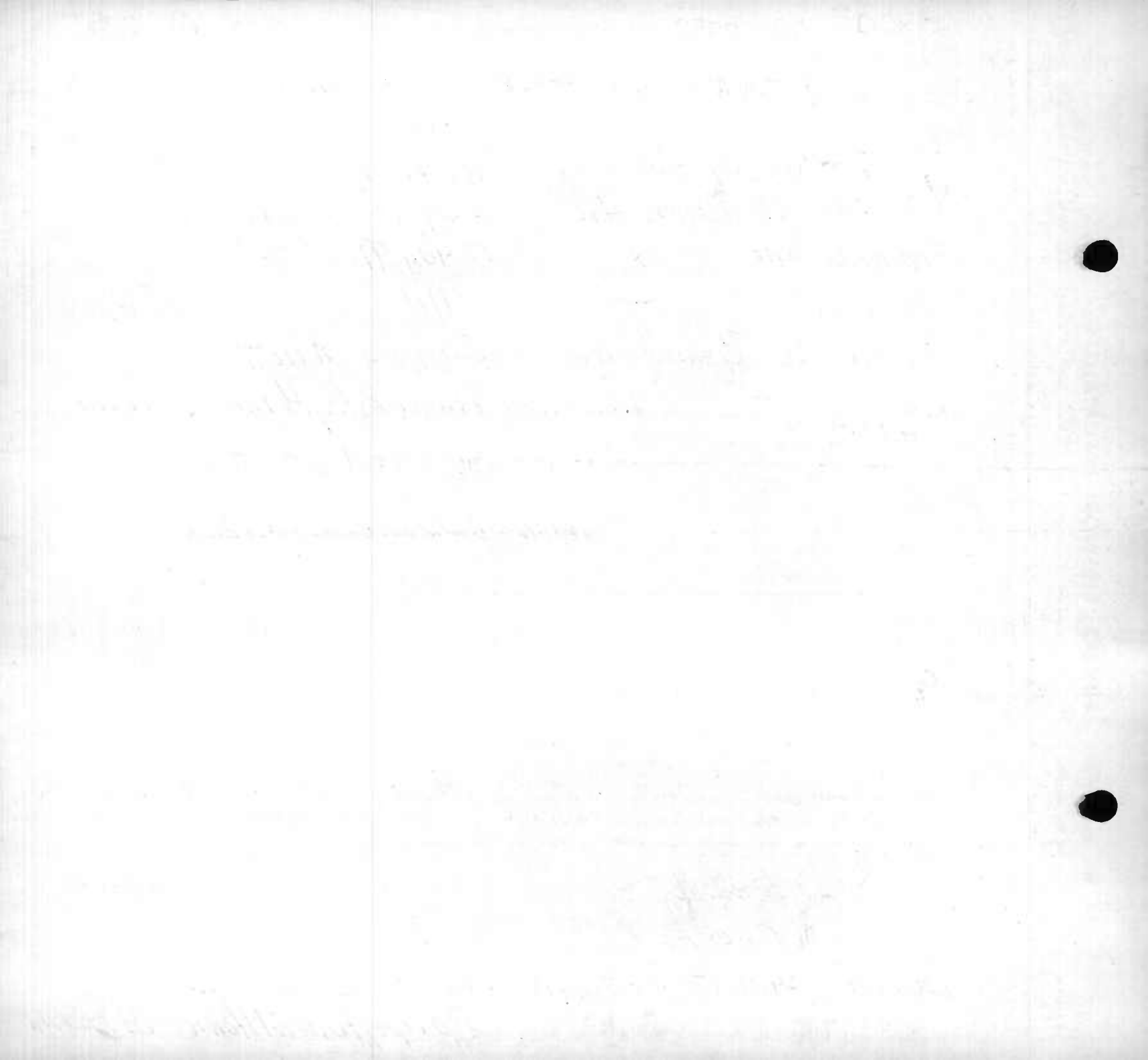
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3252</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">1-250</span>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Ethel Jackson</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">Tuesday March 24, 70</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">3801 West Garrison Ave.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">3801 West Garrison Ave.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9/8/1888</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">81</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Virginia</span>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">U.S.A.</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">David Hand</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Alice E. Tillery</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">214-20-3198</span>		<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Miss Hanna Hand 3801 West Garrison Ave.</span>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Adenocarcinoma of ascending colon</span>				
<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">with metastases to liver and mesentery</span>				
<b>20. CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Hypertension</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
<b>21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.2em;">Hypertension</span>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">6-19-68</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">adenocarcinoma of colon</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">no</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <input type="checkbox"/>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">June 4, 1968</span> <b>to</b> <span style="font-size: 1.2em;">March 24, 1970</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">March 24, 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Milton E. Lowman</span>			<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3-26-70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. Milton E. Lowman</span>			<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">1401 Reisterstown Rd. Baltimore 21208</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/27/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Lorraine Park Cemetery</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Loring Byers</span>		
<b>25D. ADDRESS</b> <span style="font-size: 1.2em;">8428 Liberty Rd. Randallstown MD. 21133</span>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 70 3253		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3253	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA B. LOSS		20 March 70 7 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
The Wesley Home			Md. 2755		
90 2211 W Rogers Ave			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			2211 W Rogers Ave		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	17 Aug 91	78	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Md. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert W Bamberger		Emma Knott		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		21210 0968D		The Wesley Home Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Myocardial infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic cardiovascular disease		
			(C) —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11 March 1970 to 20 March 1970, that (I) (we) last saw the deceased alive on 18 March 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John N Barnaby				24 Mar 70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOHN W BARNABY				165 E Belvedere Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		24 MAR 70		Baltimore Cem	
24D. LOCATION		24E. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
Baltimore Md		Ruth E. Taylor		Burgess Funeral Home Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 30 1970		Ruth E. Taylor		Burgess Funeral Home Baltimore Md	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3254</span>	
BIRTH NO. <span style="float: right;">R-500 70 3254</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Ida Ray RYAN</b>			2. DATE AND HOUR OF DEATH <b>March 25, 1970</b> <span style="float: right;">M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3014 Wylie Avenue Baltimore, Maryland 21215</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2716</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3014 Wylie Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1893</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Levin Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Ida Hern</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>- - - -</b>		
			17. INFORMANT <b>Balto. Md. ADDRESS 21215 Mrs. Mary Jane Johnson 5805 Ethelbert Avenue</b>		
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension &amp; Arteriosclerotic Cardiovascular Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the <del>hospital</del> ) attended the deceased from <b>October 1949</b> to <b>Dec. 18, 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis R. Maser M.D.</b>				23B. DATE SIGNED <b>March 26, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis R. Maser M.D.</b>				23D. ADDRESS <b>2724 Smith Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>28MAR70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>	
				ADDRESS <b>4611 Park Heights</b>	

Thyridium septentrionale

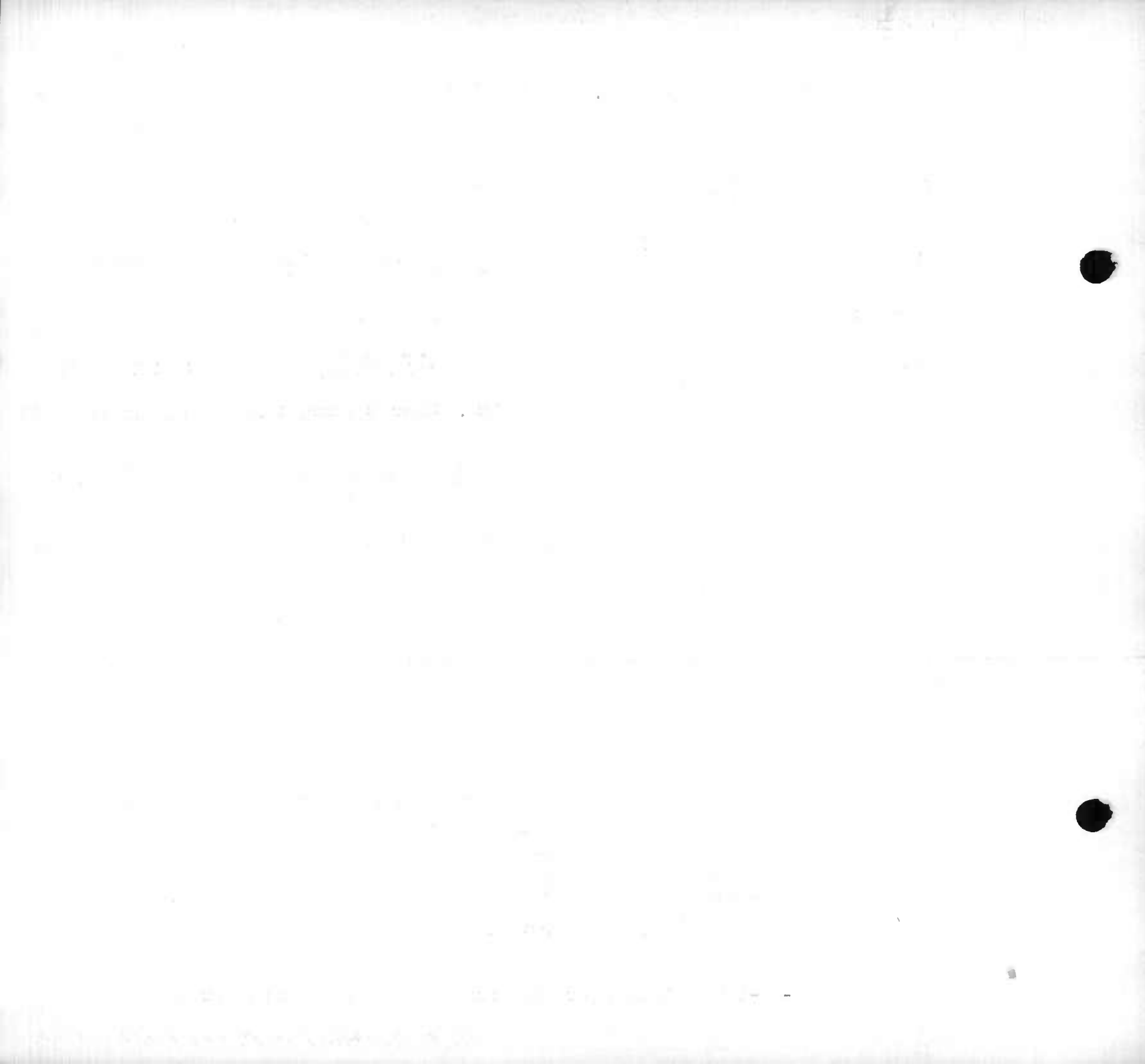
Hypotrachyna subulnaria  
Chlorocibicides

James R. Wilson M. 12

W. H. H. 12

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

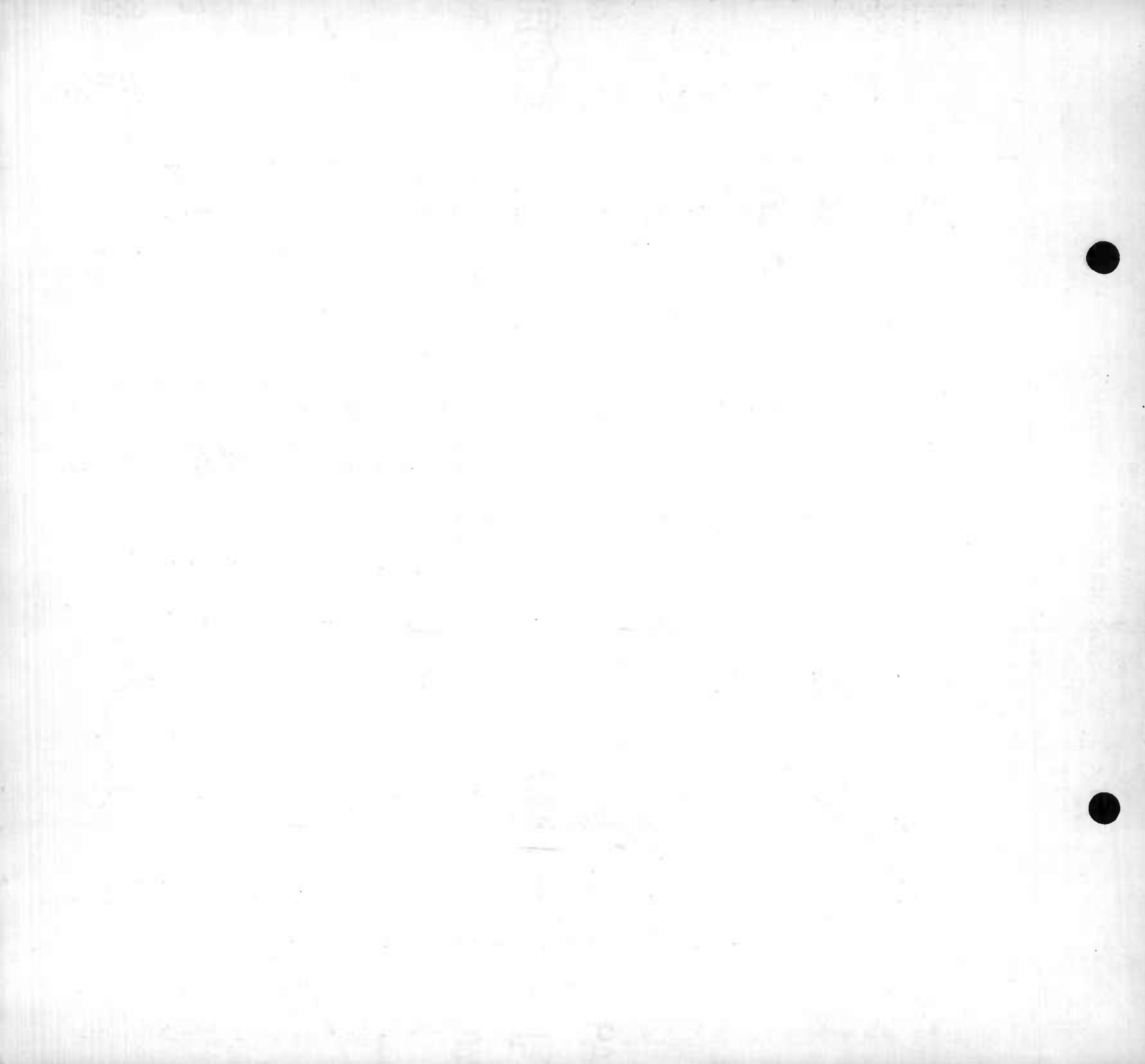
VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

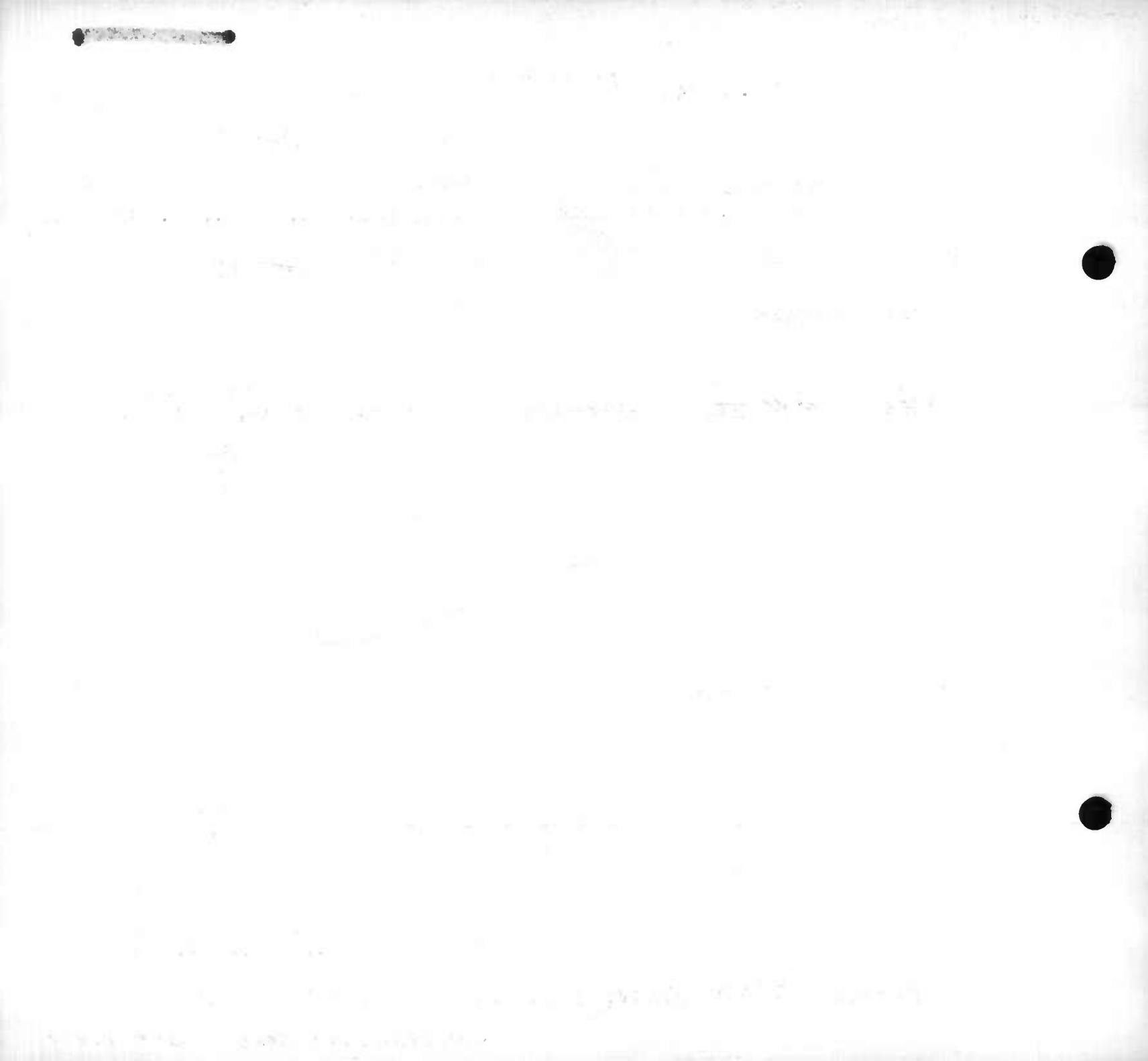
B-200 70 3256		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3256	
1. NAME OF DECEASED (Type or Print) <u>MRS. Hannah Bays</u>			2. DATE AND HOUR OF DEATH <u>3/26/70</u> <u>1:22</u> AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Hanover Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>			C. CITY OR TOWN <u>Havre de Grace</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>2145 Pulaski Hwy</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/92</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Louisa, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Isaac Hayes</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Ison</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James M. Bays, 2145 Pulaski Highway</u>
18. <u>155.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Gall Bladder</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 Mos.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u>					
19A. DATE OF OPERATION <u>6/10/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cholelithiasis</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>1</u> (this hospital) attended the deceased from <u>2/27/70</u> to <u>3/26/70</u> , that <u>1</u> (we) lost the deceased alive on <u>1/26/70</u> and that <u>1</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>George M. Hricko, M.D.</u>				23B. DATE SIGNED <u>3/26/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE M. Hricko, M.D.</u>				23D. ADDRESS <u>Box 26 Univ. Hospital Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>Mar. 26, 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Stuckey Funeral Home</u>	
24D. LOCATION <u>Morehead</u>		24E. CITY, TOWN, or COUNTY <u>Kentucky</u>		24F. STATE <u>Kentucky</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Charles E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son</u>	
25D. ADDRESS <u>Abingdon, Md.</u>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 3257</u>	
BIRTH NO. <u>K-450</u>		70 3257					
1. NAME OF DECEASED (Type or Print) <u>Truett U. Kellam</u> (KELLAM)				2. DATE AND HOUR OF DEATH <u>3/24/70</u> <u>11 10</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>BALTO</u>	
				C. CITY OR TOWN <u>ESSEX</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>142 Kingston Rd., Balto., Md. 21220 005</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-31-20</u>		9. AGE (In years last birthday) <u>49</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thurston Kellam</u>				14. MOTHER'S MAIDEN NAME <u>Bertha NORRIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>457-14-5771</u>		17. INFORMANT <u>BCH, Records: Baltimore, Maryland 21224</u>			
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH <u>Metastatic Bronchogenic (Rt.)</u> (A) IMMEDIATE CAUSE <u>adenocarcinoma -</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Metastasis (L- Frontal lobe)</u> <u>Intra spinal metastasis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Bone Metastasis</u> (C) <u>metastasis to Mandible</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Terminal metastatic tumor</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>Nov- 1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tumor of (L) Prostate</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from <u>2-19-70</u> 19 <u>70</u> to <u>3/24</u> 19 <u>70</u> that (X) (we) lost saw the deceased alive on <u>3/24</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Mehdi SARKARATI M.D.</u>						23B. DATE SIGNED <u>3/24/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Mehdi SARKARATI M.D.</u>				23D. ADDRESS <u>B.C.H. Baltimore City Hospital</u> <u>4940 Eastern Ave., Balto., Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/27/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATL CEM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>J.G. ... SONS</u>		ADDRESS <u>300 ...</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 1.5em;">70 3258</span>	
BIRTH NO. <span style="font-size: 1.5em;">H-650 70 3258</span>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Alma G Hearn</i>		2. DATE AND HOUR OF DEATH <i>3/25/70 9<sup>35</sup> A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Sinai</i>		A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>5306 Fennpark Ave</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/25/86</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>84</i>
11. BIRTHPLACE (State or foreign country) <i>Balto, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Carrick</i>		14. MOTHER'S MAIDEN NAME <i>Virginia R Miller</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
		17. INFORMANT ADDRESS <i>Wm.K.Hearn - 1710 Chesterton Rd 21207</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
I <i>Ca. Lung</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Probable myocardial infarction</i>	
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Time) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> 19 <i>70</i> to <i>3/25</i> 19 <i>70</i> that (I) (we) lost saw the deceased alive on <i>3/24</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Solomon MD</i>		23B. DATE SIGNED <i>3/25/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>MD</i>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-28-70</i>	
24C. NAME of CEMETERY or CREMATORY <i>Lorraine Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Armacost Funeral Chapel-4600 Liberty Hts</i>		ADDRESS	

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F. W.

2500

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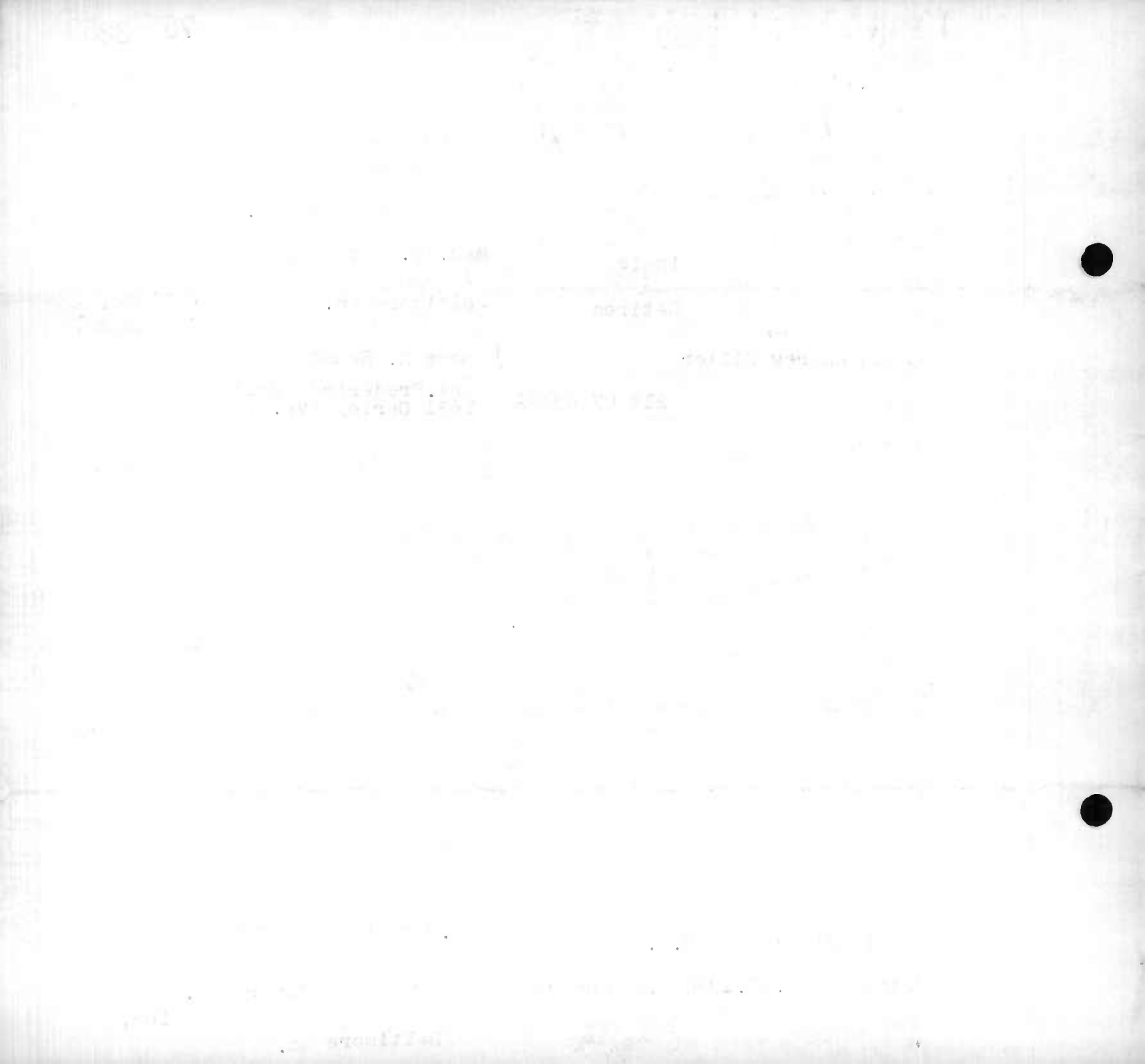
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2500

# FUNERAL DIRECTOR: IMPORTANT

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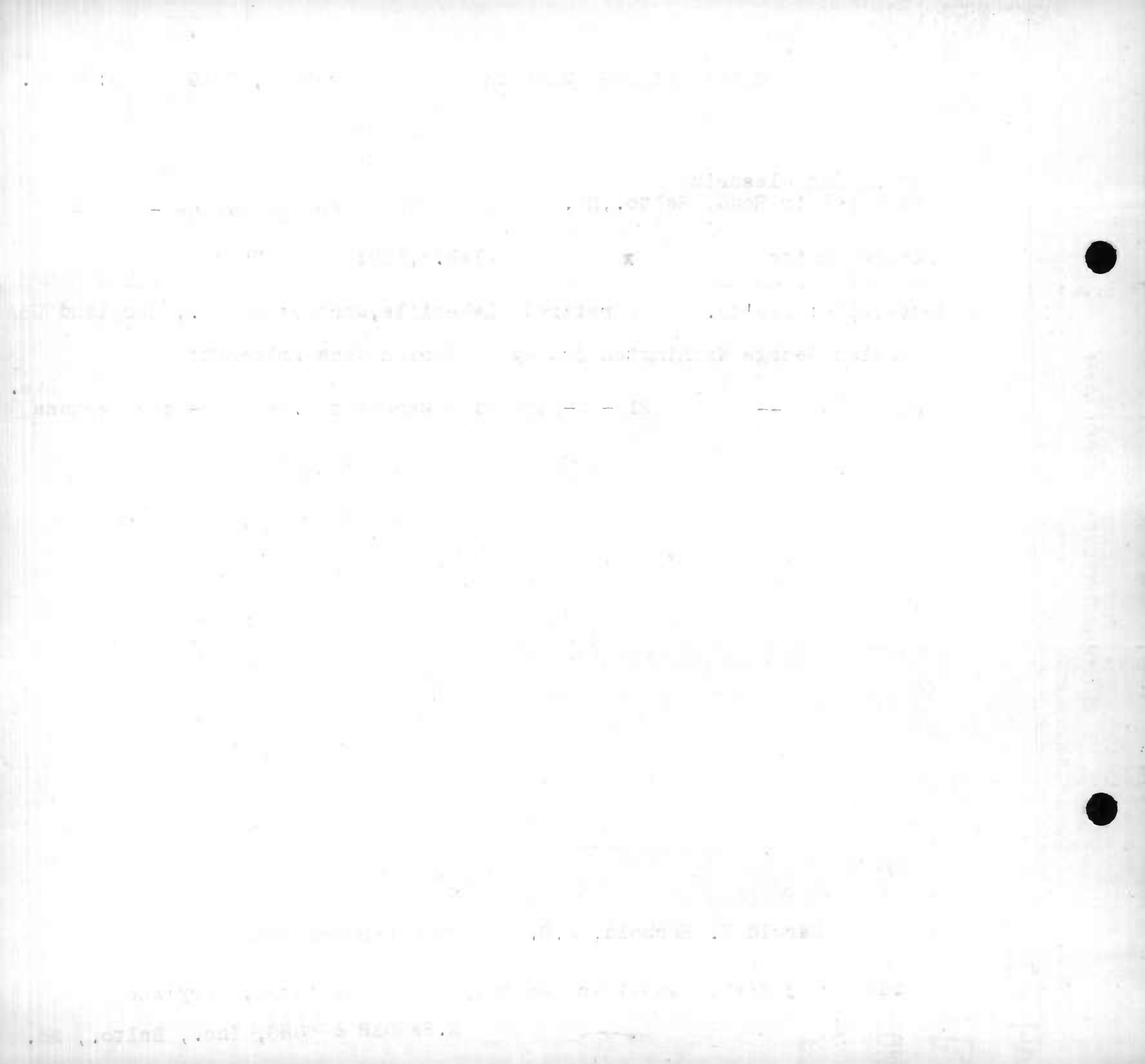
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
M-460 70 3259		<b>CERTIFICATE OF DEATH</b>		70 3259	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KATHERINE E. Miller</b>		2. DATE AND HOUR OF DEATH <b>3/23/70 9:40 p.m.</b>	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2710</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hosp.</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21212</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>		D. STREET ADDRESS (If rural, give location) <b>520 Rossiter Ave.</b>	
7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Mar. 27. 1889</b>		9. AGE (In years last birthday) <b>80</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Andrew Miller</b>		14. MOTHER'S MAIDEN NAME <b>Rose M. Schuh</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 07 0553A</b>		17. INFORMANT ADDRESS <b>Mrs. Frederick Kurrle 1631 Darley Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE Pulmonary Myoc. Infarction</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20'</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> 19 <b>70</b> to <b>3/23</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Yen</b>				23B. DATE SIGNED <b>3/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL YEN M.D.</b>		23D. ADDRESS <b>Md. General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar. 27. 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS, Inc, Baltimore Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>70 3260</u>	
W-420 <u>70 3260</u> BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		OLIVE KINIAH WALLACE		2. DATE AND HOUR OF DEATH March 23, 1960 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY <u>2733</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Gould Convalesarium 6116 Belair Road, Balto., Md.		E. STREET AND NUMBER 2600 Hermosa Avenue - 21214			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1891	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife; sec'ty.		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Lakeville, Dorchester Co., Maryland USA	
13. FATHER'S NAME William George Washington Insley		14. MOTHER'S MAIDEN NAME Mariah Jane Pritchett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-30-9530		17. INFORMANT Miss Margaret K. Wallace-2600 Hermosa Ave.	
18. <u>412.4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Failure Arteriosclerotic C-V disease associated ventricular fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: Osteoporosis-degenerative arthritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 20 yrs 4 months 8 yrs	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1943 to March 23 1970, that (I) (we) last saw the deceased olive on March 23, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. V. Harbold M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 25, 1970	
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold, M.D.		23D. ADDRESS 4706 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/26/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR H. SANDER & SONS, Inc., Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3261</b>	
W-300 <b>70 3261</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WHITE, WILLIAM C.</b>		2. DATE AND HOUR OF DEATH <b>3. 23. 70</b> <b>4. 30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>NEW YORK</b> B. COUNTY <b>V-29</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND</b> <b>38 HOSPITAL 22 S. GREENE ST.</b>		C. CITY OR TOWN <b>HAGUE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>Lakeshore Dr.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired. Accounting &amp; Cash</b>		8. DATE OF BIRTH <b>10. 10. 03</b> 9. AGE (in years last birthday) <b>66</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>AGWAY CRPS - FARMERS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>HUTSON WHITE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>GRACE BIERBOWER</b>	
16. SOCIAL SECURITY NO. <b>216-05-9494</b>		17. INFORMANT <b>HOSPITAL CHART</b> ADDRESS	
18. <b>162.1 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months &amp; 20 days</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHIOGENIC CARCINOMA</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>WITH GENERALISED METASTASIS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>congestive Heart Failure.</b> <b>Coronary artery Disease with Bld MI</b>			
19A. DATE OF OPERATION <b>162.1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>2. 11. 1970</b> to <b>3. 23. 1970</b> that (I) (we) lost saw the deceased alive on <b>3. 23. 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>HA Ahmad</b>		23B. DATE SIGNED <b>3. 23. 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAYYED T.A. SHAH</b>		23D. ADDRESS <b>University of Md. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-25-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Providence Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Blennely, Howard Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Higinbotham Slack</b>		ADDRESS <b>Ellmott City, Md.</b>	





1. NAME OF DECEASED (Type or Print) BRIAN W. HOERL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> March 24, 1970 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 24 70 9:25 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Catonsville	
9. DATE OF BIRTH Dec. 17, 1969		10. AGE (In years, last birthday) 3 17 1	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Charles H. Hoerl, Jr.		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore	
15. MOTHER'S MAIDEN NAME Bonnie Lee Good		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. ---		18. INFORMANT Charles H. Hoerl, Jr. - 306 Ingleside Ave.	

19. CAUSE OF DEATH 795 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Sudden Death in Infancy DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
---	--	---	--

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner		DATE SIGNED 3-24-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Sterling Funeral Home 736 Edmondson Ave. Catonsville, Md. 21228					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

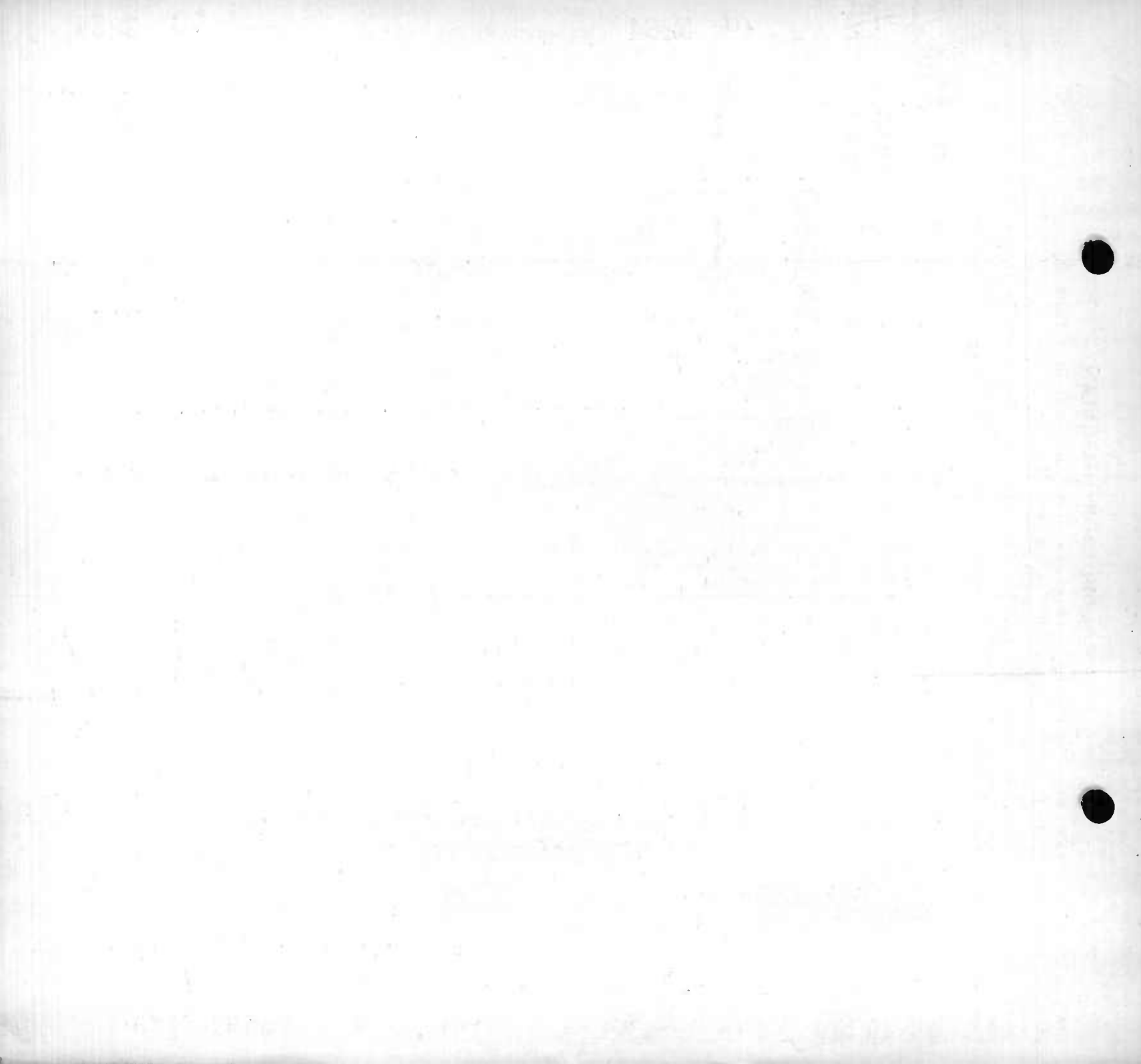
G-650 70 3263		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 70 3263	
1. NAME OF DECEASED (Type or Print) <b>GREEN, IRENE</b>				2. DATE AND HOUR OF DEATH <b>3/26/70 3:5 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Md. General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>KINGSVILLE MD</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>BRADSHAW Rd 21087</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/84</b>		9. AGE (in years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hutzelers</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES GREEN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN - Amelia Seidel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-6678</b>		17. INFORMANT ADDRESS <b>Lillian M. Green Bradshaw Rd, Kingsville, Md</b>			
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE MYOCARDIAL INFARCTION</b> <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>20 YEARS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10 AM 3/25 19 70</b> to <b>3/26 19 70</b> that (I) (we) lost saw the deceased alive on <b>3/26/70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>N Cost MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>N Cost MD</b>				23D. ADDRESS <b>MARYLAND GENERAL HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-28-1970</b>		24C. NAME of CEMETERY or CREMATORY <b>St. John's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Blenheim Balto Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME of REGISTRAR <b>John H. 7401 Belair Rd.</b>		25C. FUNERAL DIRECTOR ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70</span> <span style="font-size: 1.5em;">3264</span>	
S-365		70		3264	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Anna Marie Stran			March 26, 1970   7.30 p.m. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  443 W.24th. St.  00			A. STATE  Md.		
			B. COUNTY  1207		
C. CITY OR TOWN  Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER  443 W. 24th. St.		
5. SEX  Female	6. RACE  White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  May 11, 1896	9. AGE (In years last birthday)  73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY  Home	11. BIRTHPLACE (State or foreign country)  Md.		12. CITIZEN OF WHAT COUNTRY?  U.S.A.
13. FATHER'S NAME  Robert I. Baker			14. MOTHER'S MAIDEN NAME  Ferial		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  No.		16. SOCIAL SECURITY NO.  214-14-7516	17. INFORMANT  Joseph F. Stran 443 W.24th. St.		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> 19 <u>63</u> to <u>MARCH 26</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>MARCH 23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Reuben Hoffman, M.D.				23B. DATE SIGNED  3-28-70	
23C. PHYSICIAN'S NAME (Type)  Reuben Hoffman			23D. ADDRESS  846 W. 36th. St. Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)  Burial	24B. DATE  3-30-70	24C. NAME of CEMETERY or CREMATORIUM  Baltimore Cemetery		24D. LOCATION (City, town, or county) (State)  Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.  MAR 30 1970		25B. NAME OF REGISTRAR  Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR  Frank H. Seitz 8147 36th St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3265</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>RUSSELL STEWART.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>3-24-70</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> <b>00 716 W.34th St.</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>Md.</b> <b>B. COUNTY</b> <b>1306</b> <b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>716 W.34th St.</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-7-12</b>	<b>9. AGE</b> (In years last birthday) <b>57</b>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Plumbers Helper</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Plumber.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>	
<b>13. FATHER'S NAME</b> <b>John W. Stewart.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie Stewart.</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-07-7882</b>		<b>17. INFORMANT</b> <b>Bertie N. Miller</b> <b>ADDRESS</b> <b>716 W.34th St.</b>	
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Sudden</b>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <u>3-14</u> 19<u>65</u> to <u>3-24</u> 19<u>70</u>, that (I) (<del>we</del>) last saw the deceased alive on <u>3-12</u> 19<u>70</u> and that in (<del>my</del>) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>and</del>) (<del>did</del>) not view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Reuben Hoffman, M.D.</b>				<b>23B. DATE SIGNED</b> <b>3-26-70</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>REUBEN HOFFMAN, M.D.</b>				<b>23D. ADDRESS</b> <b>846 W. 36th St., Baltimore, Md.</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>3-26-70</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Woodlawn</b>	
<b>24D. LOCATION</b> (City, town, or county) <b>Balto. Co.</b>		<b>24E. (State)</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 30 1970</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Paul E. Ehrhardt</b>	
<b>25D. ADDRESS</b> <b>3615 Blenheim Ave</b>					

x

.c.f.

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)

.J.P. (C.D.)



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-120 70 3266		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3266	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Maxie Epps</b>			2. DATE AND HOUR OF DEATH <b>3/24/70 7 45</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Mt Sinai Nursing Home</b> <b>4613 Park Heights Ave</b> <b>Balto Md 21215</b>			A. STATE <b>Baltimore</b> B. COUNTY <b>1231 Ashland Ave 1002</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/1896</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Greenville County, Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William Epps</b>			14. MOTHER'S MAIDEN NAME <b>Mary A Moore</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO. <b>212-05-5857</b>	17. INFORMANT <b>Hornie Epps 623 2nd Ave</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>1619 I Carcinoma of large intestine</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>metastatic carcinoma of large intestine</b></b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis heart disease</b></b> <b>(C) <b>none</b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b> <b>3 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>none</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 5 1970</b> to <b>March 24 1970</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 24 1970</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel Levin</b>			23B. DATE SIGNED <b>3/24/70</b>		23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN M.D.</b>
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>3/30/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Bull. National Cemetery Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Samuel J. Carroll 1712 W. W. Ave</b>	

Carmona / large  
volubilis / in  
large tree  
disturbed / small trees

in  
in  
to

MANUEL LEVIN NO (in English) But it is  
March 20  
March 21

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">H-165</span> <span style="font-size: 1.5em;">70 3267</span> <span style="font-size: 1.5em;">BALTIMORE CITY HEALTH DEPARTMENT</span>				REG. NO. <span style="font-size: 1.5em;">70 3267</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Hebron, Richard</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-25-70</span> <span style="font-size: 1.2em;">12:30 a.</span> <span style="font-size: 0.8em;">M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">39</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Provident Hospital, Inc.</span> <span style="font-size: 1.2em;">1514 Division Street</span> <span style="font-size: 1.2em;">Baltimore, Maryland 21217</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1602</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">1309 Harlem Avenue</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4-8-83</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">86</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Unemployed</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">James Hebron</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Sarah</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-05-3553</span>			17. INFORMANT <span style="font-size: 1.2em;">Mary Reid-24 Wheeler Ave. daug.</span> <span style="font-size: 1.2em;">Mr. George Everin (Grandson) 24 Wheeler Ave.</span>		
18. <span style="font-size: 1.5em;">188 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if rise to the above cause (A) UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Carcinoma of Bladder</span> <span style="font-size: 1.2em;">with extensive pelvic metantases and possible femoral neck fracture</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Uremia</span> (C) <span style="font-size: 1.2em;">Pulmonary embolus-left terminal</span> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Months</span>		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2-28-70</span> 19 to <span style="font-size: 1.2em;">3-25-70</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-25-70</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3-25-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. M. Mathur</span>				23D. ADDRESS <span style="font-size: 1.2em;">Provident Hospital, Inc.</span> <span style="font-size: 1.2em;">1514 Division Street - Baltimore, Maryland</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">3-30-70</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Auburn Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 30 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, R.D.</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">V.R. Bailey</span> ADDRESS <span style="font-size: 1.2em;">Kelson F.H. 1348 Calhoun St.</span>		



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BALTIMORE CITY HEALTH DEPARTMENT

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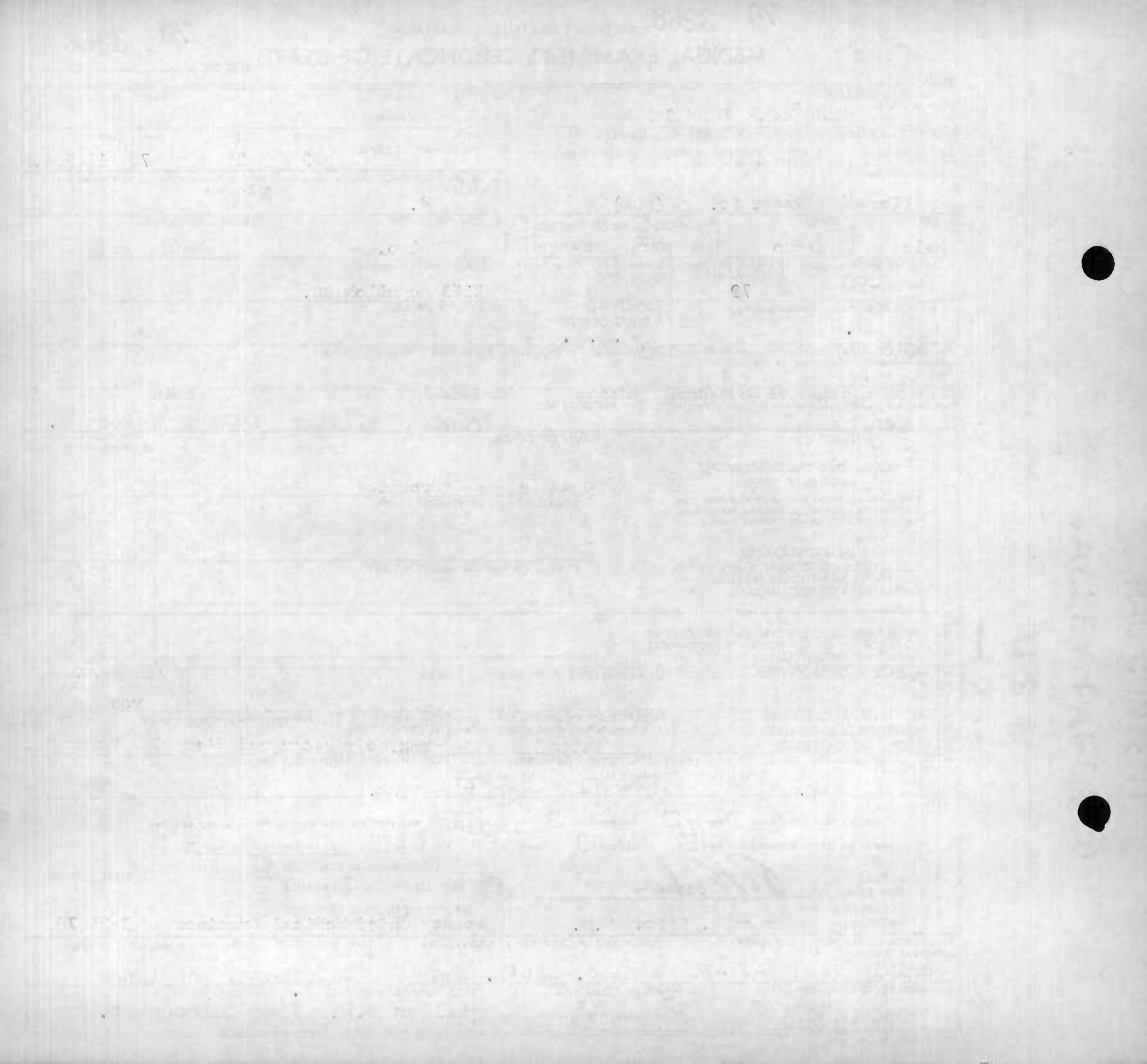
3268

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HERBERT JOHNSON GREEN</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>20 Pier #4 Pratt St. (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 24 70 11:50A.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-28-90</b>				10. AGE (In years last birthday) <b>79</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF <b>U.S.A.</b>				13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chauffeur</b>				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS <b>Frances Williams 1808 Division St.</b>			
19. CAUSE OF DEATH <b>E 984</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20. DATE OF OPERATION <b>2</b>			
21. AUTOPSY? (Yes or No) <b>yes</b>				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>water</b>				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Unk. Body recovered Pier #4 Pratt St.</b>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>Unk.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? <b>Unk.</b>				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <b>3-24-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3-27-70</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D. BY HEALTH DEPT. <b>MAR 30 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>				25D. ADDRESS <b>1348 Calhoun St.</b>			

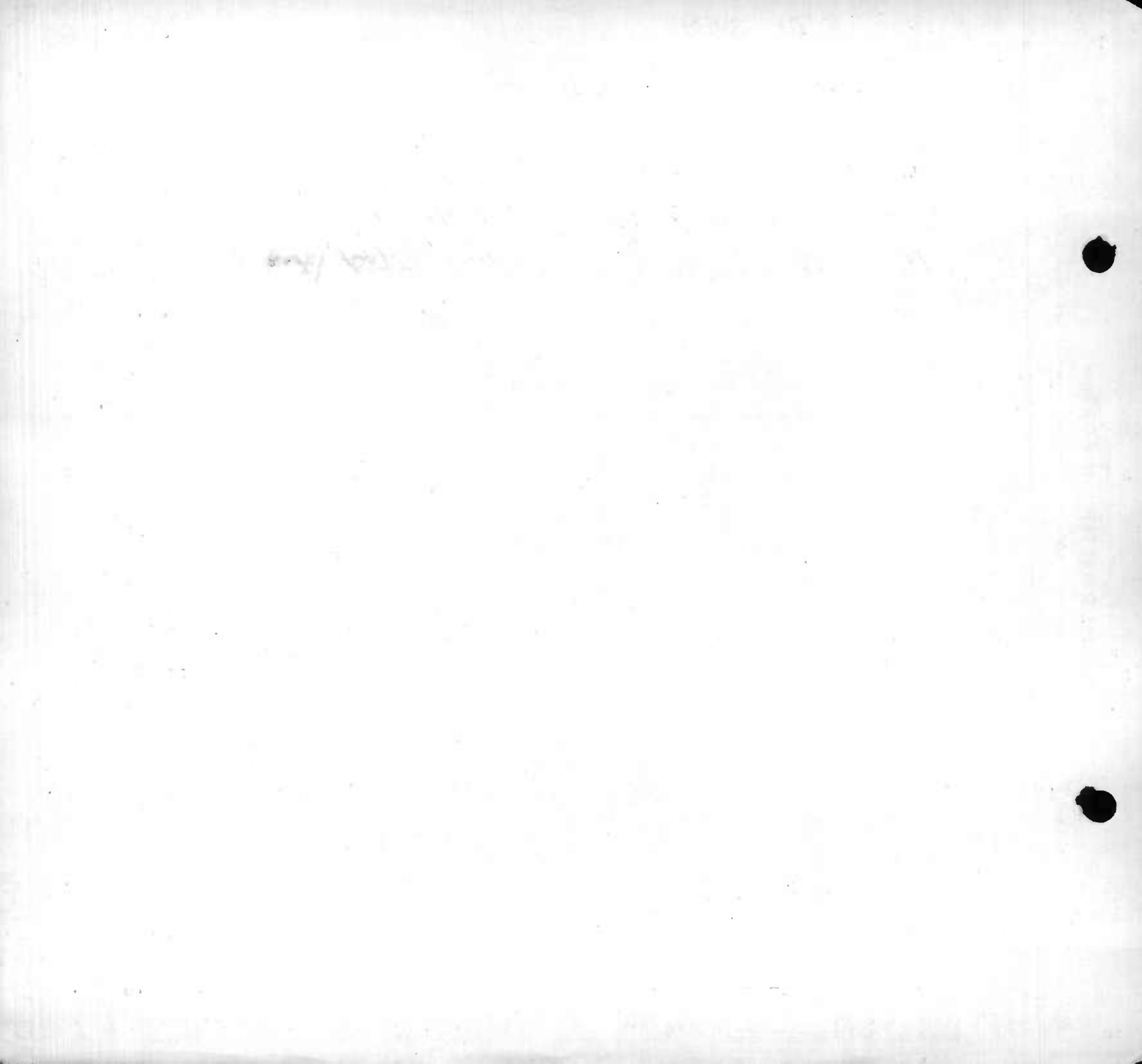


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3269</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">J-52070 3269</span> <span style="font-size: 1.5em;">BALTIMORE CITY HEALTH DEPARTMENT</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <span style="font-size: 1.2em;">JONES, JACOB. H.</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <span style="font-size: 1.2em;">3-28-70 12:50</span> <span style="font-size: 0.8em;">P.M.</span> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Lutheran Hospital of Maryland Inc</span> <span style="font-size: 1.2em;">730 Ashburton Street</span> <span style="font-size: 1.2em;">Baltimore, Maryland 21216</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">1602</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTO.</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1142 N Stricker ST.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span> <b>6. RACE</b> <span style="font-size: 1.2em;">N</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12-16-01</span> <b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">68</span> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Va.</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">HENRY JONES</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ALVERTA BUTLER</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Emma Jones</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">1142 Stricker St.</span>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div style="width: 45%;"> <b>CAUSE OF DEATH</b>  <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">AZOTEMIA</span>            DUE TO, OR AS A CONSEQUENCE OF:   <b>(B) PNEUMONIA</b>            DUE TO, OR AS A CONSEQUENCE OF:   <b>(C)</b> </div> <div style="width: 10%; text-align: center;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">3. 23. 70</span>   <span style="font-size: 1.2em;">3. 28. 70</span> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>II</b>            OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  <span style="font-size: 1.2em;">Cerebro-vascular Accident</span> </div> <div style="width: 55%;"> <b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">NO</span> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> </div> </div>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3. 23.</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3. 28</span> 19 <span style="font-size: 1.2em;">70</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3. 28.</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">G. GANES M.D.</span> <b>DEGREE</b>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3. 28. 70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">G. GANES. M.D.</span> <b>DEGREE</b>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Lutheran Hosp. Ashburton St. Balto.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">4-2-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Church Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">Northumberland Co., Va.</span>		<b>24E. (State)</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">V.R. Bailey</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">1348 N. Calhoun St</span>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3270</u>	
T-652 70 3270		CERTIFICATE OF DEATH			
BIRTH NO. <u>162.1</u>		1. NAME OF DECEASED (Type or Print) <u>ADAM TURNAGE Sr.</u>			
2. DATE AND HOUR OF DEATH <u>3/27/70 2 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		<u>1/8 Maryland General Hospital</u>			
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>2778 Tivoli Ave.</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/1900</u>	9. AGE (in years last birthday) <u>69</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Turnage</u>		14. MOTHER'S MAIDEN NAME <u>Jenny Crandel</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>244-01-3226</u>		17. INFORMANT <u>Adam Turnage</u> ADDRESS <u>2778 Tivoli Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u>		<u>6-8 wks</u>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Extension and Dissemination of Bronchogenic Carcinoma</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3/22/1970</u> to <u>3/27/1970</u>		that (I) (we) last saw the deceased alive on <u>3/27/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>M. S. Al-Ibrahim M.B.Ch.B.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>M. S. AL-IBRAHIM M.B.</u>	
23D. ADDRESS <u>Md. General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-1-70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>Kelson F.H. 1348 Calhoun St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

X-624		70 3271		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3271	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Charles Kreisel</i>			
2. DATE AND HOUR OF DEATH <i>3/25/70 10 45 A M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Parkhill Nursing Home</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Balto.</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1630 Myssola Rd</i>				5. SEX <i>MALE</i> 6. RACE <i>White</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>10/2/80</i> 9. AGE (In years last birthday) <i>89</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GUARD</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Security</i>			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Otto Kreisel</i>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-48-4442</i>			
17. INFORMANT <i>Erne Kreisel</i>				ADDRESS <i>915 Ellendale Dr.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CHF acute</i> (B) <i>Generalized ASCVD</i> (C) <i>old era/hernia</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>26 Feb 1969</i> to <i>25 Mar 1970</i> , that (I) (we) last saw the deceased alive on <i>25 Mar 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Hulla MD</i>				23B. DATE SIGNED <i>25 Mar 70</i>		23C. PHYSICIAN'S NAME (Type) <i>J. Hulla MD</i>	
23D. ADDRESS <i>2214 E. Fayette St</i>				23E. CITY, TOWN, OR COUNTY <i>Baltimore</i>		23F. STATE <i>Maryland</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-28-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 30 1970</i>		25B. NAME OF REGISTRAR <i>William E. Johnson</i>		25C. FUNERAL DIRECTOR <i>William E. Johnson</i>		ADDRESS <i>8521 Loch Raven Blvd. Baltimore, Maryland 4</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-163		70 3272		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3272	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) SAMUEL LEOPARD			
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 4-6-70 The Johns Hopkins Hospital 33				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
3. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 8002 Oakleigh Road			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/18	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY 7-11 Store		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold LaFayette Leopard		14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXX</del> Annie Camp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 250-01-0451 -254-01-0451	
17. INFORMANT Mrs. Marie Leopard		ADDRESS 8002 Oakleigh Road		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SHOCK 2 <sup>nd</sup> HEMORRHAGE SEROSAL TEAR ESOPHAGO-CARDIAC 18 hrs LEFT VENTRICULAR HYPERTROPHY	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 32-23-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED esophageal reflux		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-22 1970 to 3-24 1970, that (I) (we) last saw the deceased alive on 3-24-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John W. Baker Jr MD				23B. DATE SIGNED 3-24-70		23C. PHYSICIAN'S NAME (Type) John W. Baker Jr MD	
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-26-70		24C. NAME OF CEMETERY or CREMATORY Lake View Memorial Park	
24D. LOCATION Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William E. Johnson	
ADDRESS 8521 Loch Raven Blvd. Baltimore, Maryland 4							

V.S. 153

4-6-70

M.H.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-120 70 3273		BALTIMORE CITY HEALTH DEPARTMENT		70 3273	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>RUBY REVIS</b>		2. DATE AND HOUR OF DEATH <b>MARCH 19, 1970, 240 AM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		<b>Unknown</b>		<b>North Carolina</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>231-26-0429</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH Records: Baltimore, Md. 21224</b>	
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEPATO-RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CIRRHOSIS LIVER</b> <b>CHRONIC ALCOHOLISM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6yrs plus</b> <b>6yrs plus</b> <b>10yrs plus</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Anemia</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>March 16</b> 19 <b>70</b> to <b>March 19</b> 19 <b>70</b> that (1) (we) last saw the deceased alive on <b>March 18</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dale N. Schumacher MD</b>				23B. DATE SIGNED <b>March 19, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dale N. Schumacher, M.D.</b>		23D. ADDRESS <b>Baltimore City Hospital</b> <b>4940 Eastern Ave., Balto., Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/27/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>					
25A. DATE REGD-BY HEALTH DEPT. <b>MAR 20 1970</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W north Ave</b>	





70 3274

# BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3274

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JACOB DOFFLEMYER

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐Month  
Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

D.O.A.

South Balto. General Hosp.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March

26, 1970

?

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2403

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

8/5/1915

10. AGE (in years  
last birthday)

59 5/4

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1442 Williams St.

11. BIRTHPLACE (State or foreign country)

ELKTON, VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS DOFFLEMYER

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RAILROADMAN

148. KIND OF BUSINESS OR INDUSTRY

RAILROAD

15. MOTHER'S MAIDEN NAME

LENNIE COOK

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

229 01 6513

18. INFORMANT

ELLA MAE DOFFLEMYER

ADDRESS

ABOVE ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive and arteriosclerotic cardiovascular

(A) IMMEDIATE CAUSE

disease

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/27/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

3/30/70

24C. NAME OF CEMETERY OR CREMATORY

LUTHERAN MEMORIAL

24D. LOCATION

(City, town, or county)

(State)

SHENANDOAH, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.

MAR 30 1970

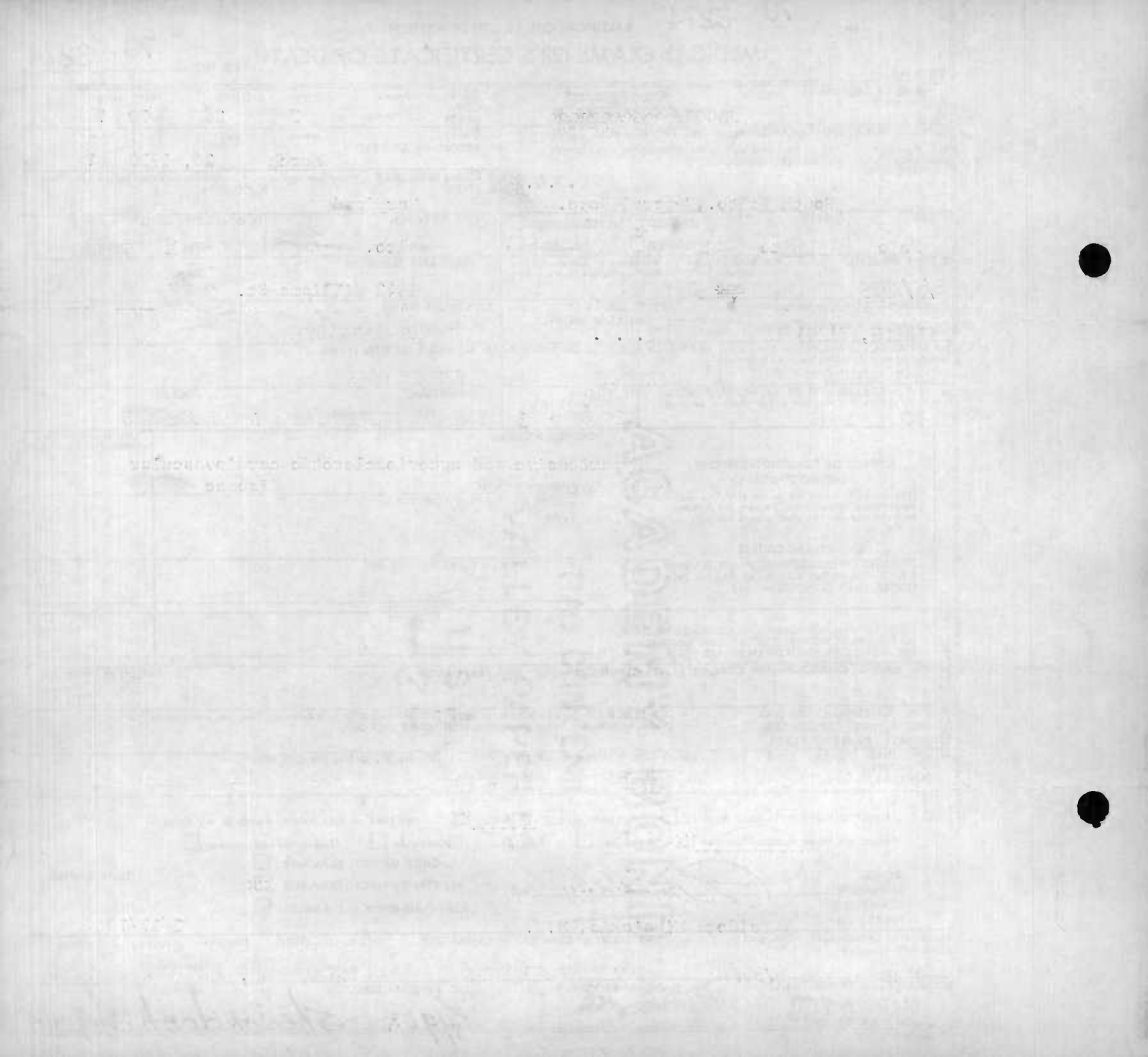
25B. NAME OF REGISTRAR

Robert E. Talbot, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

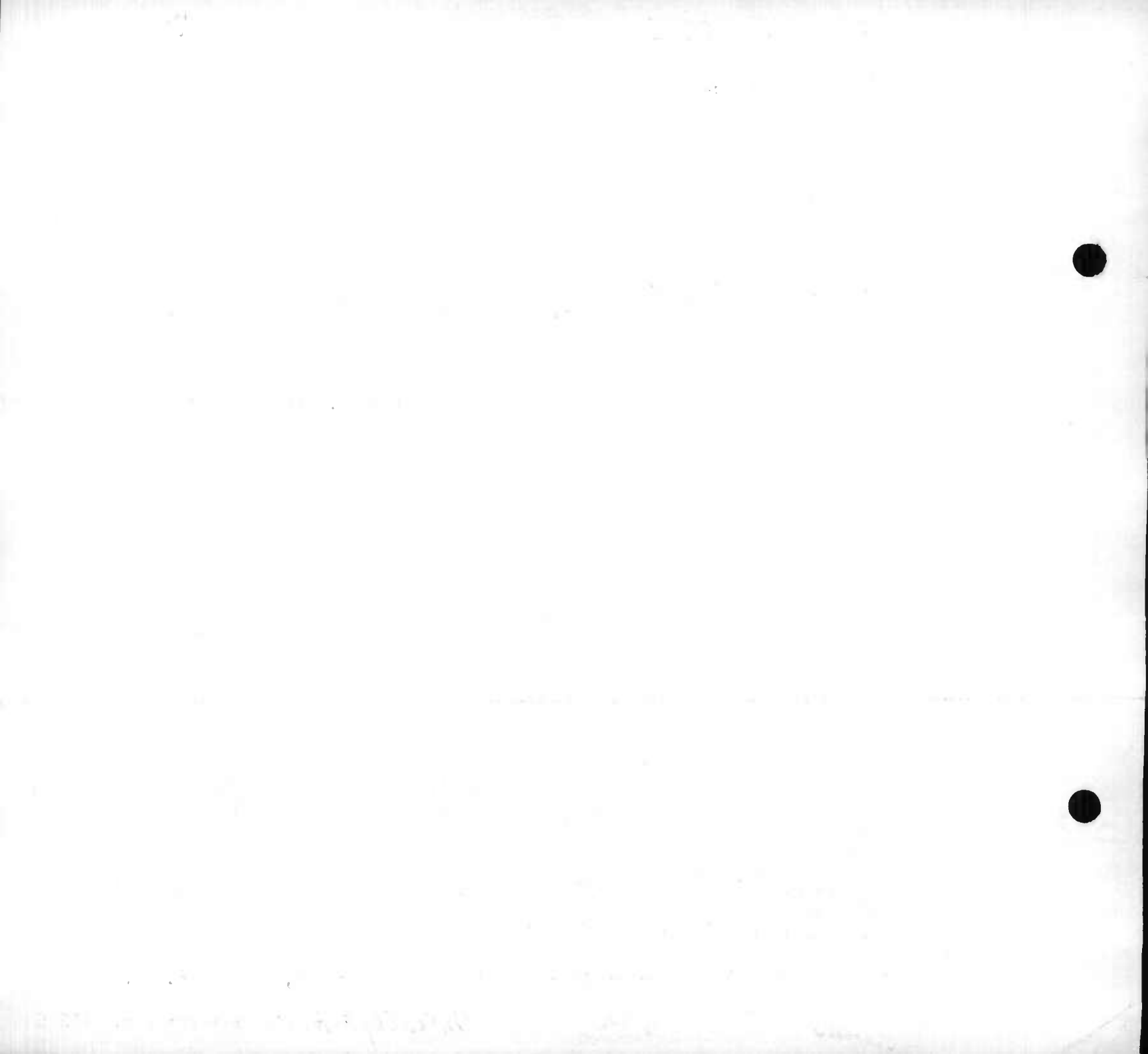
Kyger - Shenandoah - Virginia



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-153 70 3275				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3275	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 3-25-70 4:40 M.			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2534				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3504 7th St. Baltimore MD 21225				F. FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NURSING HOME			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-04	
9. AGE (In years lost birthday) 65		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? ESTONIA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Operator FRUIT COMPANY				10B. KIND OF BUSINESS OR INDUSTRY United Fruit Co.			
11. BIRTHPLACE (State or foreign country) ESTONIA				12. CITIZEN OF WHAT COUNTRY? ESTONIA			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Lilvand				16. SOCIAL SECURITY NO. #16-30-5804			
17. INFORMANT Mrs. Eleanor R. Lilvand				ADDRESS 3504 7th Street 21225			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 185 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cancer - Prostatic Metastasis to Pelvis & Spine (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Cordis Degeneratio				?			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/31/69 to 3/24/70 that (I) (we) last saw the deceased alive on 3/24/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum MD				23B. DATE SIGNED 3/25/70		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD	
23D. ADDRESS 1115 N CALVERT ST				23E. ATTENDING PHYSICIAN Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk		24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCallum F.H. 237 Patapsco Ave. 21225			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

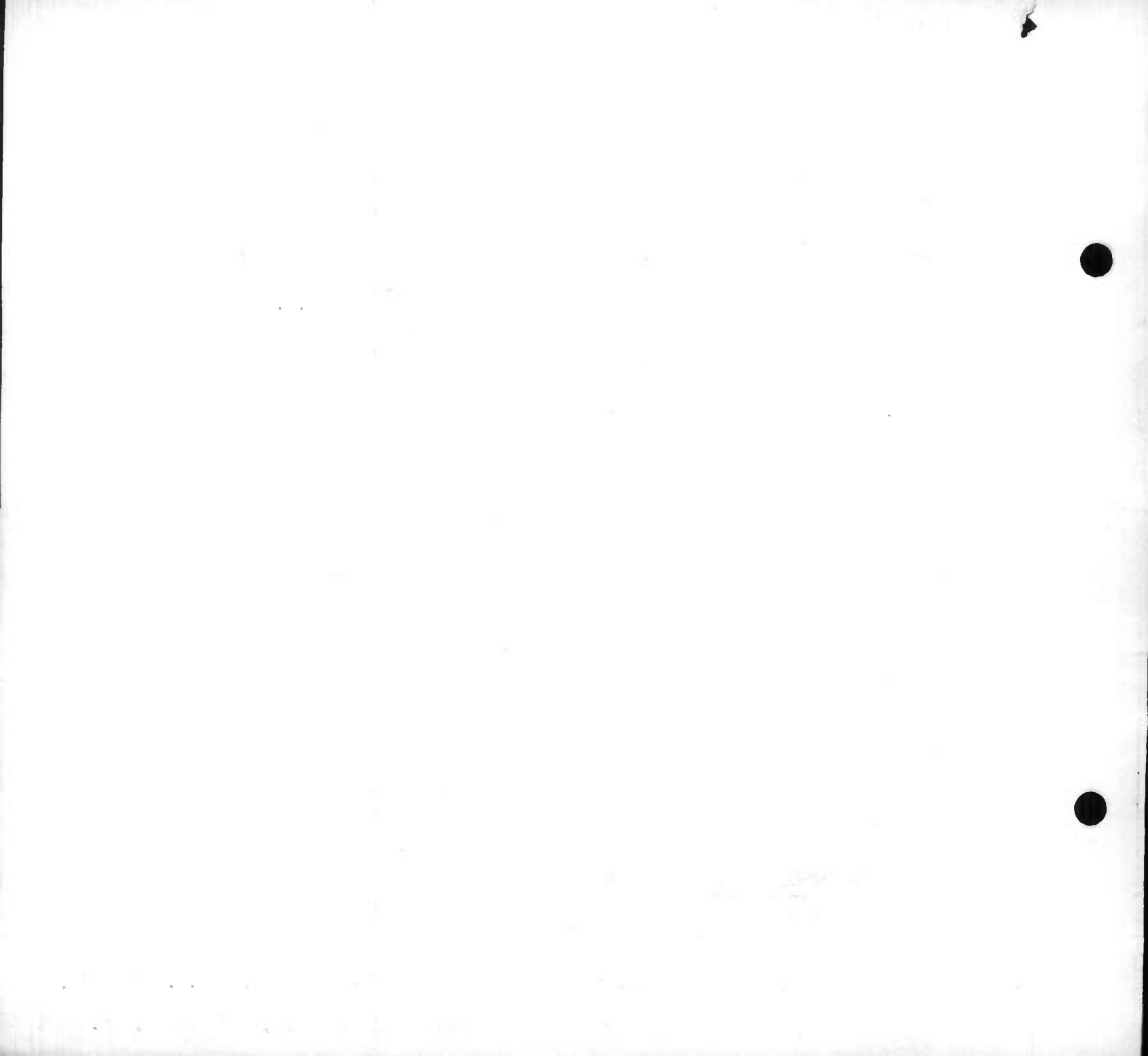
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3276</b>
<b>P-320</b> <b>70 3276</b> <b>CERTIFICATE OF DEATH</b>		<b>BIRTH NO.</b> <b>1</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>MARY ALVA POTTS</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>3/23/70</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>90 CENTURY NURSING HOME</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>402</b>		
<b>5. SEX</b> <b>FEMALE</b>		<b>6. RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>HOUSE WIFE</b>		<b>8. DATE OF BIRTH</b> <b>SEPT. 13, 1905</b>
<b>13. FATHER'S NAME</b> <b>ALBERT SMITH</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>JOHANNA WELSH</b>		<b>9. AGE</b> (In years last birthday) <b>64</b>
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>ALVA BROWN 209 W. MCCOMAS ST.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>
<b>18. I</b> <b>410.9</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cardio Respiratory Failure</b> <b>Ac Myocardial Infarction</b> <b>Arteriosclerotic CVD</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>0</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>0</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>0</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>0</b>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>0</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>0</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Mar 22 19 68</b> <b>Mar 23 19 70</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Mar 23 19 70</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (we) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>William D. Appleford</b>		<b>23B. DATE SIGNED</b> <b>3/26/70</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>William D. Appleford</b>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>24B. DATE</b> <b>3/26/70</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>LORRIANE CEMETERY</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 30 1970</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		<b>25C. FUNERAL DIRECTOR</b> <b>McGilly, 30 E. Fort Ave.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		70 3277		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3277	
BIRTH NO.				REG. NO.					
1. NAME OF DECEASED (Type or Print) <u>Cook Muriel</u>				2. DATE AND HOUR OF DEATH <u>3/24/70</u> <u>9 30</u> PM.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hosp.</u> <u>38 BARTO, Md 21201</u>				A. STATE <u>Md</u>		B. COUNTY <u>Kent (229)</u>		C. CITY OR TOWN <u>Kennedyville</u>	
						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>Md 21645</u>	
5. SEX <u>♀</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/3/09</u>		9. AGE (in years last birthday) <u>61</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY FARMER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard J. Citrester</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Duvall</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>218-48-5815</u>		17. INFORMANT <u>Hosp. Record</u>		ADDRESS	
18. <u>441.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC tamponade</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Rupture Aorta</u> (B) <u>Due to, or as a consequence of:</u> <u>Aortic Aneurysm, Ascending</u> (C) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> 19 <u>70</u> to <u>3/24</u> 19 <u>70</u> and that (I) (we) lost saw the deceased alive on <u>3/24</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Edw. J. Fowler</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>M. H. GONZALEZ</u>		23D. ADDRESS <u>U. of Maryland Hosp. BARTO. Md 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>3/28/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Sudlersville, Q.A. Co; Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Jolley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Edward Fellows &amp; Son, Millington, Md. 21651</u>			

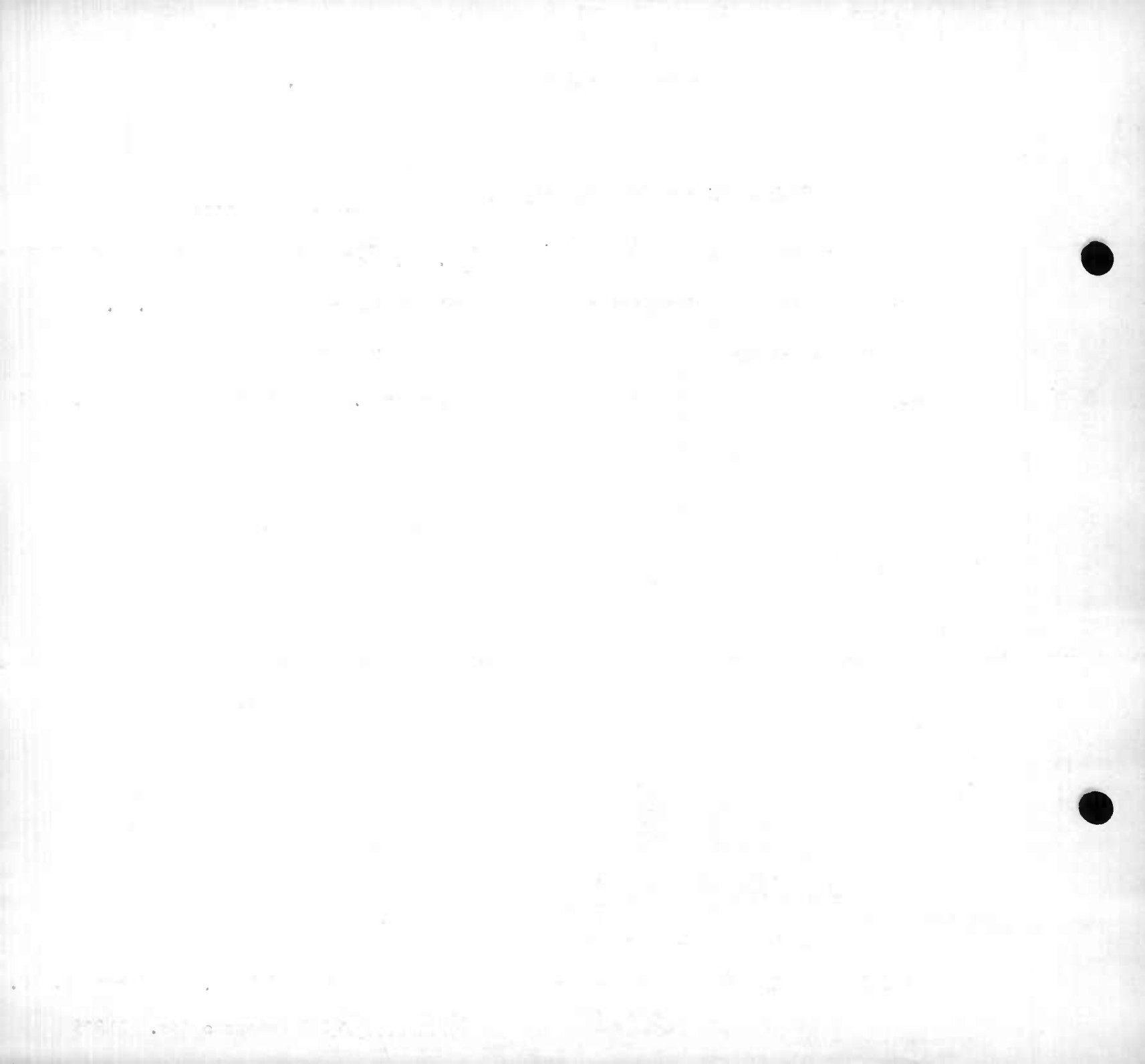




# FUNERAL DIRECTOR: IMPORTANT

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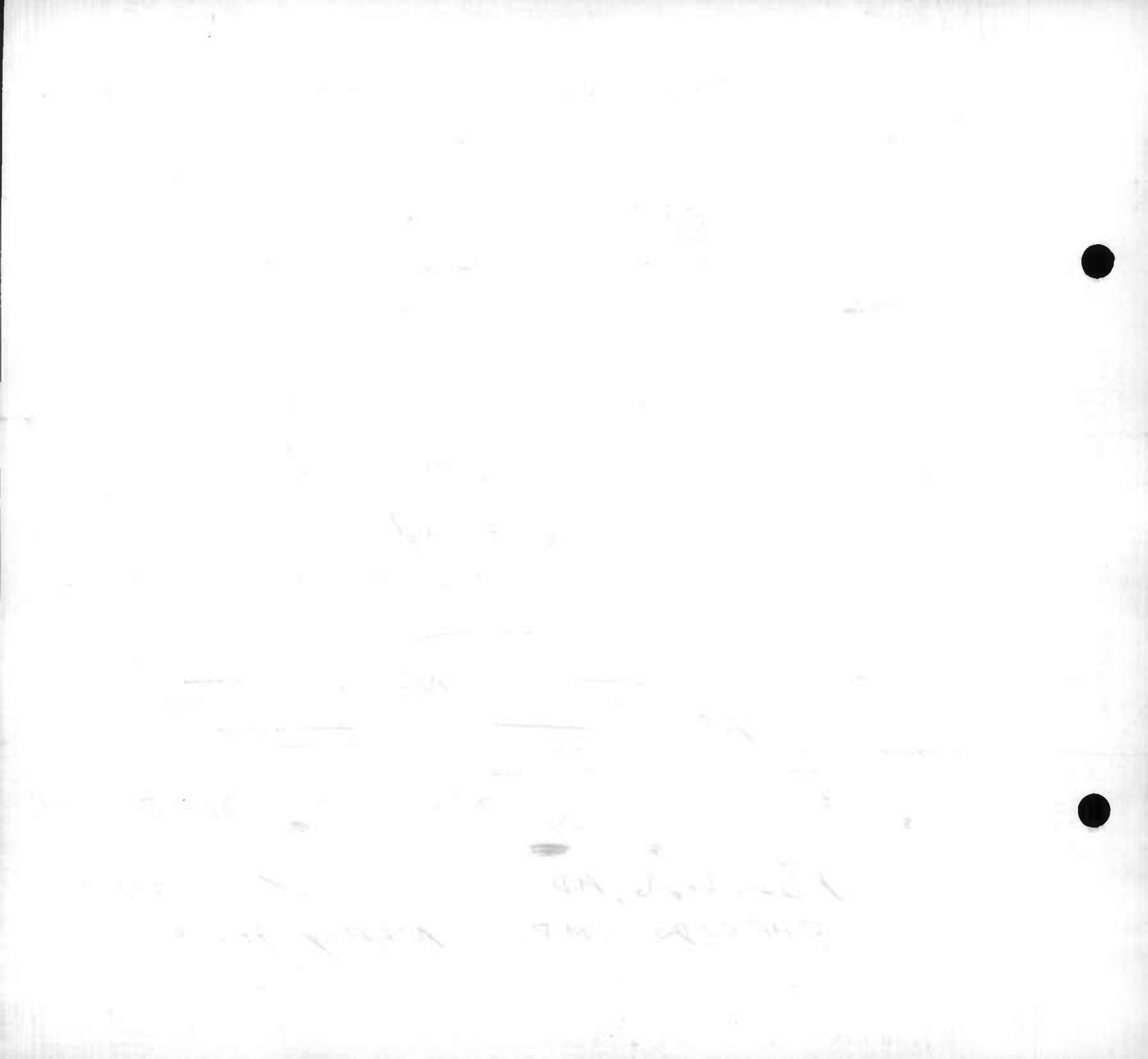
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3278	
P-455 BIRTH NO.		70 3278		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Bernard Frederick Pohlman</b>			2. DATE AND HOUR OF DEATH <b>March 25, 1970</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hosp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1012 Druidon Court 21225</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1901</b>	9. AGE (In years last birthday) <b>69 yrs</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>William Pohlman</b>			14. MOTHER'S MAIDEN NAME <b>Pauline Hof</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Emma C. Pohlman 1012 Druidon Ct. 21225</b>		
18. <b>491X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>obstructive pulmonary emphysema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>de bronchitis</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene Schnitzer</i> DEGREE			23B. DATE SIGNED <b>3-27-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>EUGENE SCHNITZER M.D.</b> FOR <b>HENRY SUMMERS, M.D.</b> DEGREE			23D. ADDRESS <b>3904 S. HANOVER ST. BALTO. MD. 21225</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/30/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	24D. LOCATION (City, town, or county) (State) <b>Trump Mill Rd. Baltimore Co. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	25C. FUNERAL DIRECTOR ADDRESS <b>McElly P.H. 237 Patapsco Ave. 21225</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-325 70 3279		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Eva Vaitzckunas (Vaitekunas)		3-25-70 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 808 St. Paul Street	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-71
9. AGE (in years last birthday) 95		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 56 4730 J1	
		17. INFORMANT Midtown Nsg Hane 808 St Paul St	
		ADDRESS	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CVA, acute	
		(B) CVA, old	
		(C) Generalized atherosclerosis	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 3/21 1970 to 3/25 1970 that (we) lost saw the deceased alive on 3/25 1970 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE V Barbado, M.D.		23B. DATE SIGNED 3/25/70	
23C. PHYSICIAN'S NAME (Type) BARBADO, M.D.		23D. ADDRESS MERCY HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-26-70	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cen		24D. LOCATION Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR Thomas J. Kenny, Inc		ADDRESS 1600 Hollins St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>W-435 70 3280</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 70 3280</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>LOUISE ANGELA WHEELTON</b></p> <p><i>Mrs Louise Wheelton</i></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><b>3/23/70 11:35 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>Bon Secours Hospital</b></p> <p><i>34</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>1901</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1410 W. Balt. St</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>1926</b> 9. AGE (in years last birthday) <b>43</b></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore City</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b></p>	
<p>13. FATHER'S NAME <b>John Kursch</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Angela LANDOWSKI</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>None ??</b></p>	
<p>17. INFORMANT: <b>SISTER</b> ADDRESS <b>21206 Mrs. Evelyn K. Lit-5304 A Eastbury Av.,</b></p>			
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Carcinomatous</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>8 months</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>8 months</b></p> <p>(B) <b>8 months</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <b>Pedicularis capitis</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION <b>0 AUG 69</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cabrest</b></p>	<p>20A. AUTOPSY? (Yes, or No) <b>No</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) 1Month 1Day 1Year (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (H) (this hospital) attended the deceased from <b>3-23-70 4pm 19</b> to <b>3-23-70 11:40pm 19</b> that (I) (we) last saw the deceased alive on <b>3-23-70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Jam b Kerr MD</b></p>		<p>23B. DATE SIGNED <b>3-24-70</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>IAIN C. KERR MD</b></p>		<p>23D. ADDRESS <b>BON SECOURS HOSP BALTO #23</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>	<p>24B. DATE <b>3/26/70</b></p>	<p>24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEMETERY</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b></p>	
		<p>25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av., Cityl</b></p>	



C-625

70

3281

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3281

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John Edward J. Cragen</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>517 Cathedral St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>3 19 70 12:30 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>April 18, 1909</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pierce J. Cragen</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1102</b>	
15. MOTHER'S MAIDEN NAME <b>Agnes Collins</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1934 to 1937</b>	
17. SOCIAL SECURITY NO. <b>504 12 2862</b>		18. INFORMANT <b>HA Rev. Damian B. Cragen Detroit, Mich</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <b>3/20/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/26/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 29 1970</b>		25B. NAME OF REGISTRAR <b>George E. Gonce</b>	
25C. FUNERAL DIRECTOR <b>George E. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. Baltimore, Md. 21225</b>	

1953 67

NO 1251  
MEDICAL EXAMINATION CERTIFICATE

1953 67

Name of Person Examined	
Address	
Occupation	
Date of Examination	
Place of Examination	
Examiner's Signature	
Examiner's Title	
Institution	
Remarks	

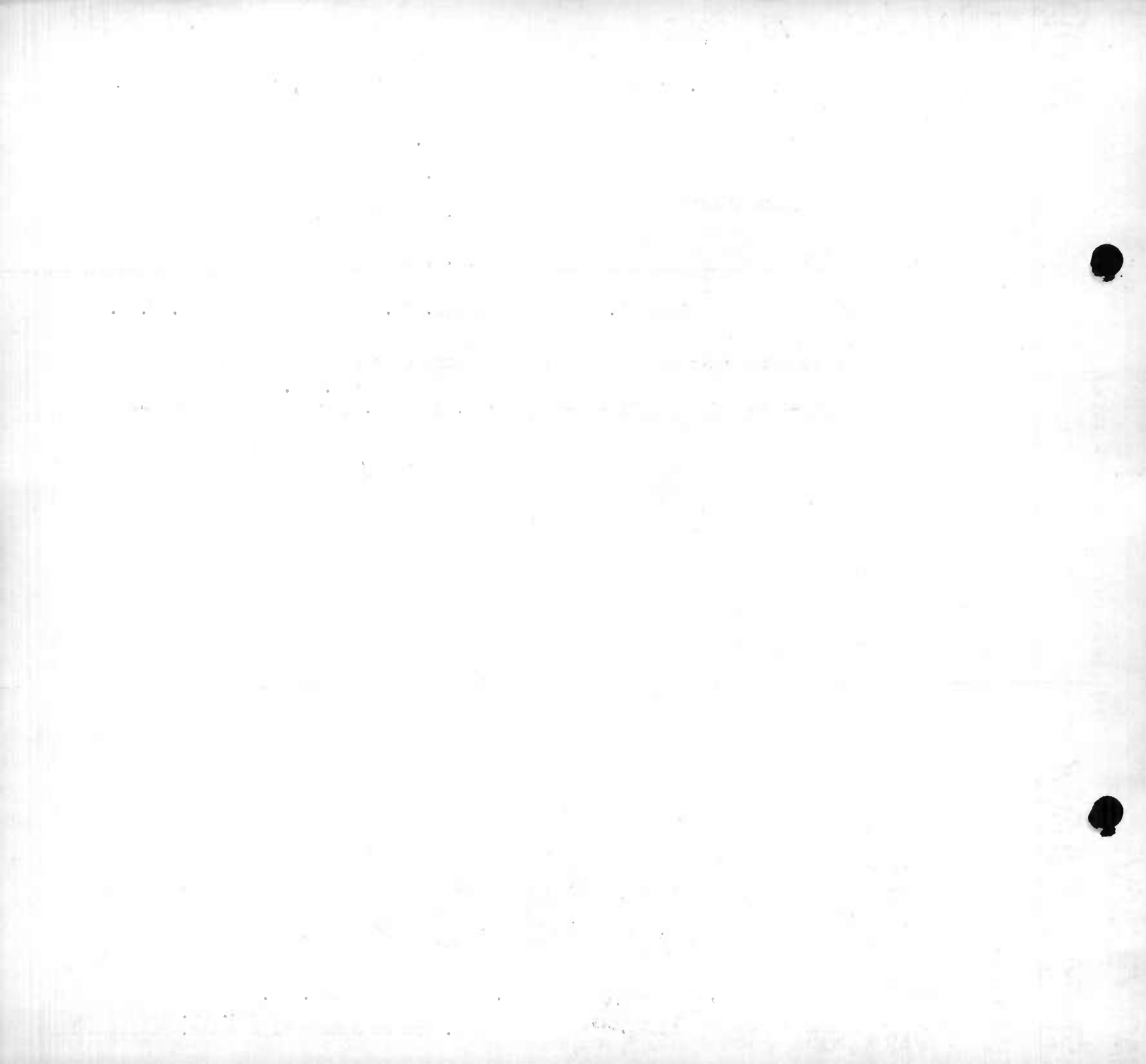
Signature of Person Examined  
Date of Signature



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3282</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">William H. Matthes</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">March 24, 1970</span> <span style="float: right;">3 A. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">1003 Cooks Lane</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2834</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Balto.</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1003 Cooks Lane</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Oct. 8, 1906</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">63</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mold Maker</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Glass Co.</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Balto. Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Frederick Matthes</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Anna Bomberg</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 1942-1945		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-10-8253</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Balto. Md. 21229</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">Mrs. Alice L. Matthes 1003 Cooks Lane</span>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 35%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">3 yrs</span> </div> </div> <div style="margin-top: 10px;"> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>  <span style="font-size: 1.5em; font-family: cursive;">Cirrhosis Liver</span> </div> <div style="margin-top: 10px;"> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> </div> <div style="margin-top: 10px;"> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">March 1 1950</span> <b>to</b> <span style="font-size: 1.2em;">March 24 1970</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">March 24 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">C. J. Mendelis MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/26/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">C. J. Mendelis MD</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">2308 Edmondson Ave</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">March 27, 1970</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Loudon Park Cem.</span>	
<b>24D. LOCATION</b> (City, town or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>		<b>25A. DATE REC'D. BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher MD</span>			
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Balto. Md. 21229</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">G. Truman Schwab 5151 Balto. National Pike</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3283</u>	
M-242				CERTIFICATE OF DEATH	
BIRTH NO. <u>70 3283</u>		1. NAME OF DECEASED (Type or Print) <u>SOPHIE MEISELES</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>March 25 '70 2:40 PM.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
5. SEX <u>F</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Goods</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>11-20-4</u>	
13. FATHER'S NAME <u>Samuel</u>		14. MOTHER'S MAIDEN NAME <u>Lenta</u>		9. AGE (In years last birthday) <u>65</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-12-3618</u>		17. INFORMANT <u>PATIENT</u>	
18. <u>183.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>TERMINAL STATE</u> DUE TO, OR AS A CONSEQUENCE OF:		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
(B) <u>OVARIAN CA &amp; multiple</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>metastasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>March 25 1970</u> to <u>March 25 1970</u> that (X) (we) last saw the deceased alive on <u>March 25 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. San Gabriel</u>		23B. DATE SIGNED <u>March 25 '70</u>		23C. PHYSICIAN'S NAME (Type) <u>I. SAN GABRIEL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/26/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Chesa Chavez Closed</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sylvan Lewis &amp; Son</u>	
25D. LOCATION (City, town, or county) <u>Randallstown</u>		25E. ADDRESS <u>9610 Randallstown Rd</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

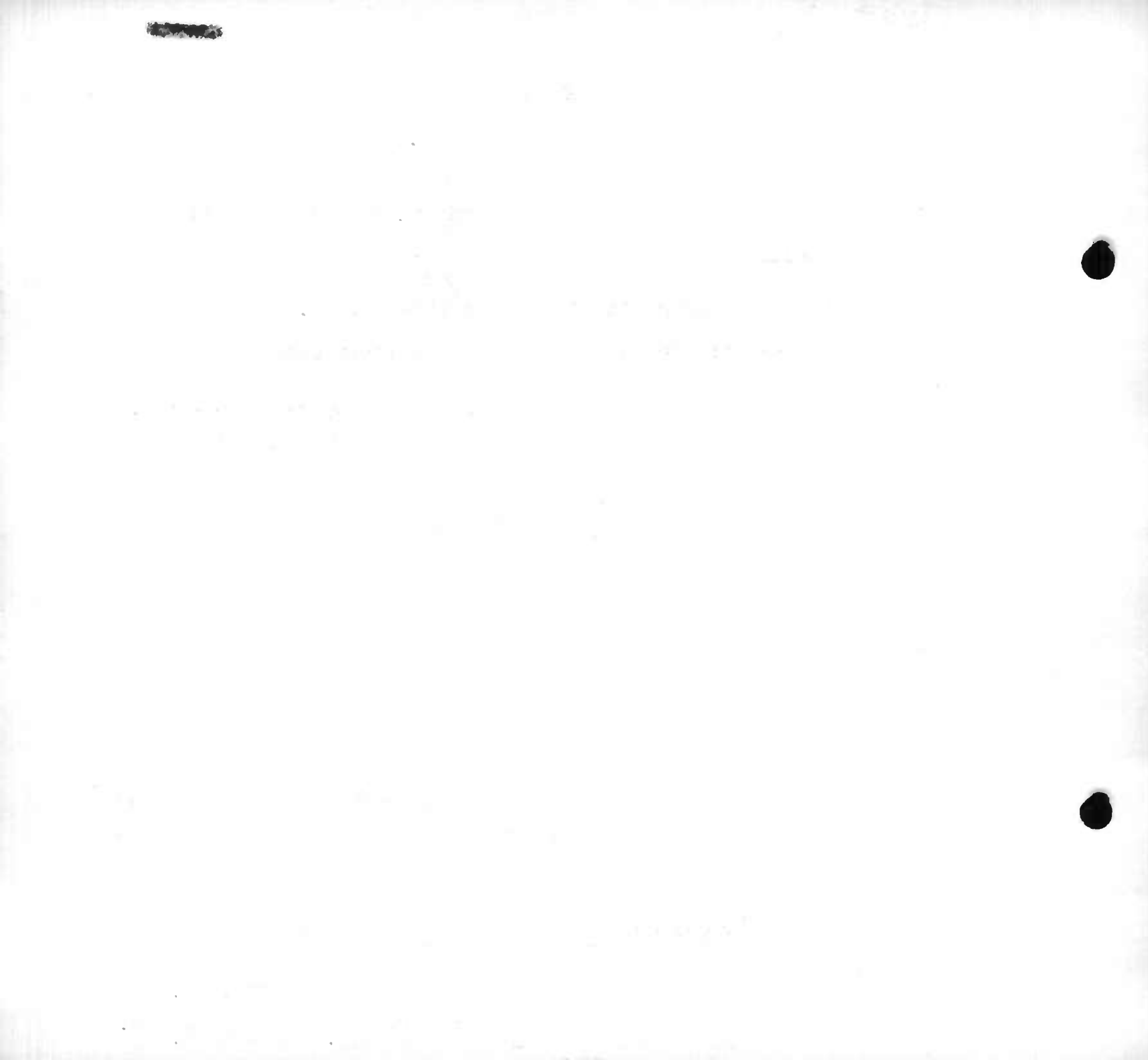
Baltimore City Health Department				REG. NO. 70 3284	
C-500 70 3284		BIRTH NO.		70 3284	
1. NAME OF DECEASED (Type or Print) <i>Lena M Conway</i> (also known as Magdalena)			2. DATE AND HOUR OF DEATH <i>3-24-70 5:00 pm</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>MD. Gen Hos</i>			A. STATE <i>Md.</i> B. COUNTY <i>21230</i>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <i>1020 W. Barre Street</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-22-76</i>	9. AGE (in years last birthday) <i>94</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired Housewife at home</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		
13. FATHER'S NAME <i>George W. Strohrmann</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Schmidt</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>218-50-3430</i>			17. INFORMANT ADDRESS <i>Mae Dix, dght., 4019 Shannon Drive</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sudden myocardial infarction</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Stomach</i>		
			(C) <i>general adenocarcinoma of stomach</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<i>arteriosclerosis</i>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-11-70</i> 19 to <i>3-24-70</i> 19 that (I) (we) last saw the deceased alive on <i>3-23-70</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R.V. Rangle</i> (Rangle)				23B. DATE SIGNED <i>3-24-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>R.V. Rangle MD</i>				23D. ADDRESS <i>2938 St Paul St Bkth. Mt (18)</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/28/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 30 1970</i>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		25D. ADDRESS <i>3331 Brehms Lane</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-435		70 3285		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3285	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Elizabeth Flottemesch</i>				2. DATE AND HOUR OF DEATH <i>3/23/70</i> <i>9:28 AM</i> NR.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>HARBOR VIEW MCC</i> <i>1213 LIGHT ST.</i>				A. STATE <i>Md., 21224</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>416 N. Streeper Street</i>			
5. SEX <i>F</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/7/84</i>	9. AGE (In years last birthday) <i>85</i>	10. If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Armco Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Heindrick Flottemesch</i>				14. MOTHER'S MAIDEN NAME <i>Theresa Bush</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>214-24-7616</i>		17. INFORMANT <i>1319 Bunsen Way</i> ADDRESS <i>Elizabeth Rogers, grand-dght.</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>cardio-respiratory failure</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>for ASCVD</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>years.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Bed sores; senile debilitation</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/6/69</i> to <i>3/23/70</i> that (I) (we) last saw the deceased alive on <i>3/23/70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J.C. Arroyo, MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/24/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>J.C. Arroyo, MD</i>				23D. ADDRESS <i>Harbor View Nursing Home</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/26/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, JR.</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		ADDRESS <i>2601 E. Madison St.</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

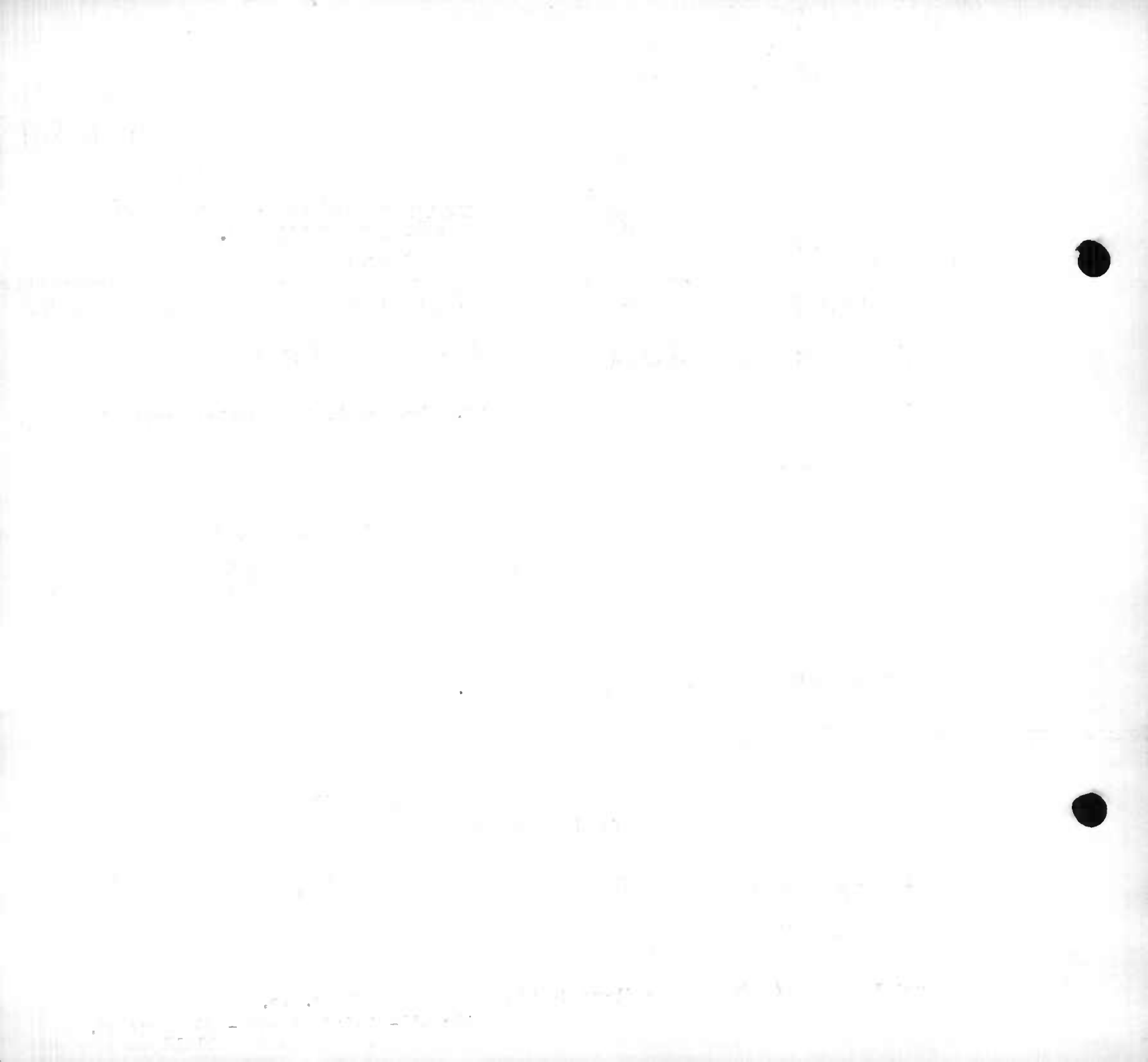
S-140		70 3286		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3286	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SVEHLA Mary Elizabeth				25 Mar 70 12:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Park Hill Convalescent Home				Md., 21231			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				415 N. Duncan Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	27 Aug 1896	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Charwoman		Lang's Pickles		Baltimore Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Ries				Catherine Heim			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		216 098915		James W. Svehla, son, 240 S. Madeira St.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CVR  HCRD  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Phenyle Post Menopausal spotting			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11 Aug 69 19 to 25 Mar 1970, that (I) (we) lost saw the deceased alive on 25 Mar 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Holla M.D.				25 Mar 70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. Holla M.D.				2214 E Fayette St 21231			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/28/70		Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 30 1970		R. E. J. J. J.		Schimunek Funeral Home, Inc.		2601 E. Madison St.	



# FUNERAL DIRECTOR: IMPORTANT

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B-620 70 3287		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		X REG. NO. 70 3287	
1. NAME OF DECEASED (Type or Print) <b>BURKE VIVIAN D.</b>				2. DATE AND HOUR OF DEATH <b>3-26-1970 4:20 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b> C. CITY OR TOWN <b>U.S.A.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSP.</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>Street 21218</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-62-51</b>		If Under 1 Yr. Months: Days: Hours: Min. <b>19</b>		9. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>NELSON E. BURKE</b>				14. MOTHER'S MAIDEN NAME <b>EDNA clemens</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Mrs. Edna Hoehl, 912 Imperial Court 21229</b>			
18. <b>743.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>intracerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>due to cerebrovascular malformation</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 minute</b> <b>3 days</b> <b>birth</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>16 PM 3/24/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>intracerebral hemorrhage</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>N2</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>N2</b>			
21D. TIME OF INJURY (APPROX.) <b>N2</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-1970</b> to <b>3-26-1970</b> that (I) (we) last saw the deceased alive on <b>4 PM 3/24/70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Moazzenzadeh</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-26-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. Moazzenzadeh</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3288</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">H-251 70 3288</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">ALSO FRANCIS HIGINBOTHOM</span> <span style="font-size: 1.2em;">Frank Higinbothom</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/23/70</span> <span style="float: right;">4:50 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">18 Maryland General Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Md.</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">Baltimore</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">6101 Loch Raven Blvd.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Cauc.</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">5/26/98</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">71</span>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">MFCT. AGENT</span>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Baltimore MD</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">MAURICE HIGINBOTHOM</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Emily Paul</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">221817828</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Chart MRS. SARAH HIGINBOTHAM</span>			<b>ADDRESS</b> <span style="font-size: 1.2em;">SAME</span>		
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">72 hrs</span>	
<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Myocardial infarct</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>					
<b>(B) Arteriosclerotic Heart Disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>					
<b>(C) <span style="font-size: 1.2em;">Bronchopneumonia</span></b>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.2em;">Pneumonia</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2/28</span> <span style="font-size: 1.2em;">1970</span> to <span style="font-size: 1.2em;">3/23</span> <span style="font-size: 1.2em;">1970</span></b> <b>that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/23</span> <span style="font-size: 1.2em;">1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Lloyd B. Mandel</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/23/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Lloyd B. Mandel, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Maryland General Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/26/70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">DRUID RIDGE CEMETERY</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">PIKEVILLE BALTO MD.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, R.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <span style="font-size: 1.2em;">Mitchell-Wiedefield 6500 York Road</span>			

W. J. - 10/10/10

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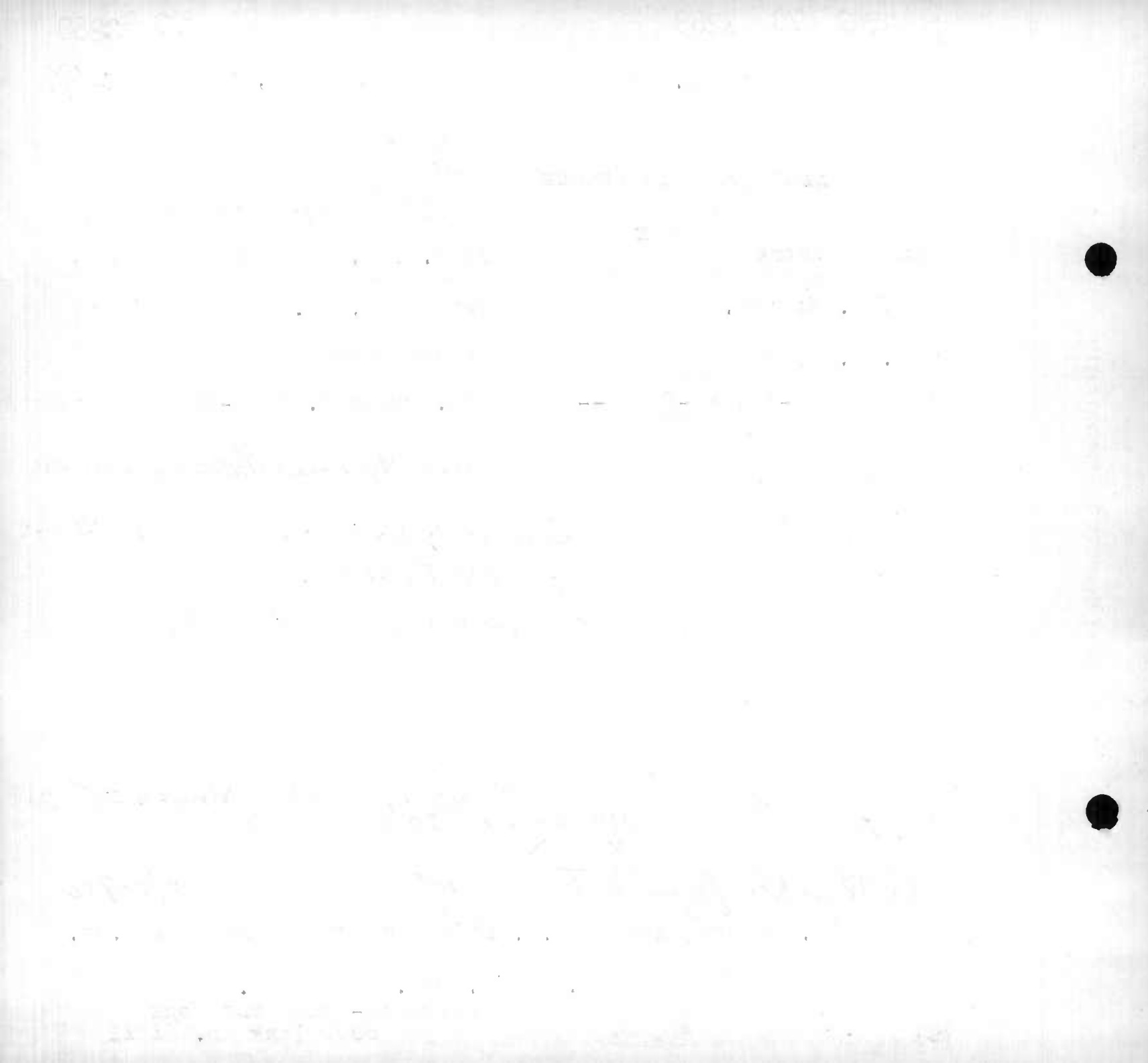
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3289	
B-630 70 3289				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. BYRD</b>				2. DATE AND HOUR OF DEATH <b>MARCH 25, 1970</b> 6 <sup>15</sup> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1106 GITTINGS AVENUE</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1106 GITTINGS AVENUE</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 6TH, 1897</b>		9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VET. ADMSTR.</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SALISBURY, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>GEO. W. BYRD</b>		
14. MOTHER'S MAIDEN NAME <b>EDITH NELSON</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW-1 &amp; WW-2</b>		
16. SOCIAL SECURITY NO. <b>--</b>			17. INFORMANT <b>MRS. HELEN M. BYRD-1106 GITTINGS A</b>		
18. <b>410.9 + 1188X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CORONARY ARTERY DISEASE</b> <b>A.S.C.V. DISEASE</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE MYOCARDIAL INFARCTION 1 WEEK</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY ARTERY DISEASE 12 YEARS</b> (C) <b>A.S.C.V. DISEASE</b>		
19. DATE OF OPERATION <b>0</b>			20. AUTOPSY? (Yes or No) <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this <del>X</del> hospital) attended the deceased from <b>JUNE 6, 1958</b> to <b>MARCH 25, 1970</b> , that (I) <del>(X)</del> last saw the deceased alive on <b>MARCH 24, 1970</b> and that in (my) <del>(X)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(X)</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur Karfgin M.D.</b>				23B. DATE SIGNED <b>3/25/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. ARTHUR KARFGIN M.D.</b>				23D. ADDRESS <b>1532 HAVENWOOD ROAD BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NAT'L. CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO.</b>		25A. DATE REC'D-BY HEALTH DEPT. <b>MAR 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. NAME OF FUNERAL DIRECTOR <b>MITCHELL WIEDEFELD HOME</b>			
25D. ADDRESS <b>6500 YORK RD. 21212</b>					

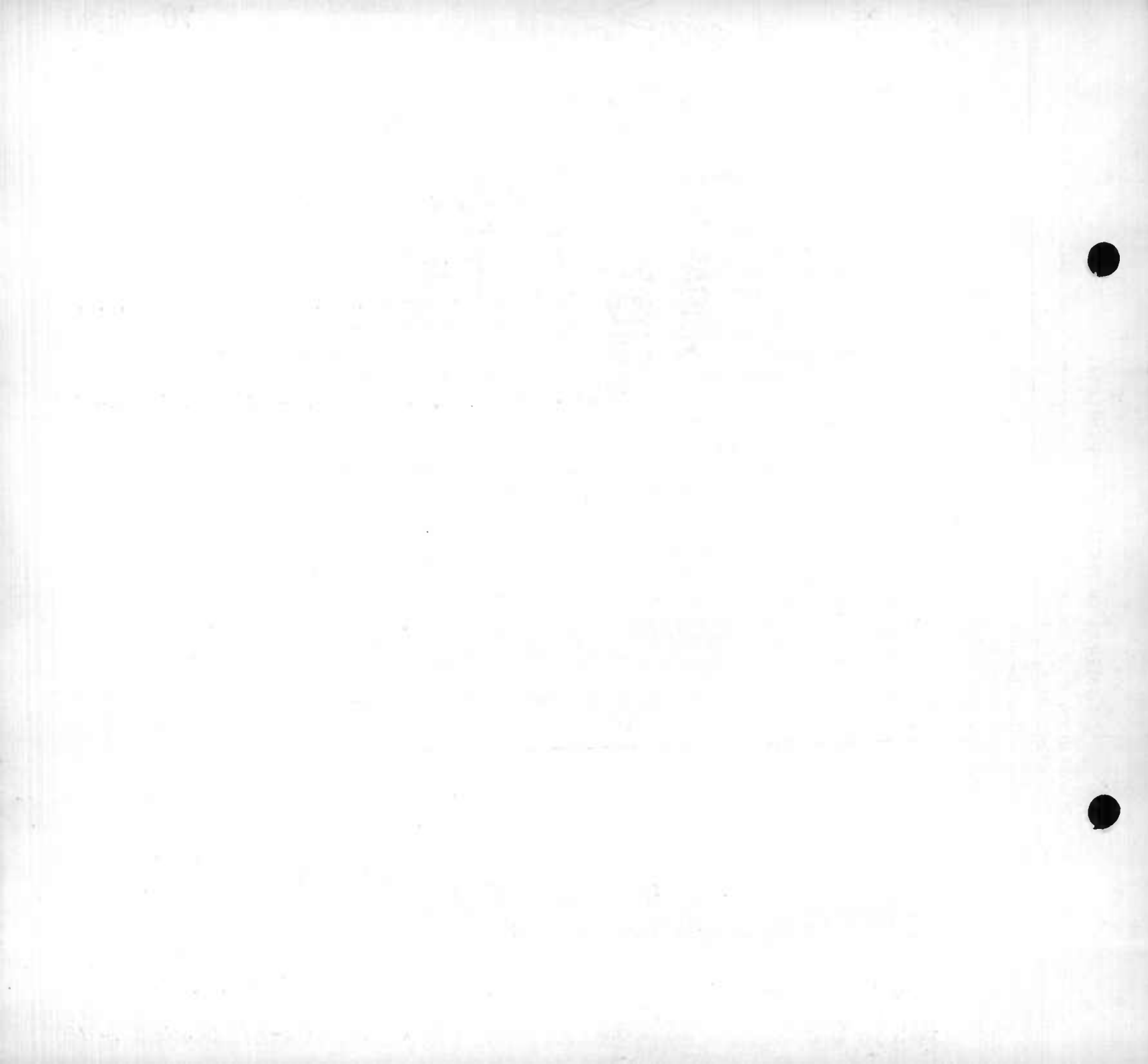




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3290</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">H-263 70 3290</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <span style="font-size: 1.2em;">John Hazard</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3-24-70 1:40 P M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span> <span style="font-size: 1.2em;">44 THE UNION MEMORIAL HOSPITAL</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <span style="margin-left: 20px;">B. COUNTY</span> <span style="font-size: 1.2em;">Baltimore 841</span> <b>C. CITY OR TOWN</b> <span style="margin-left: 20px;">D. INSIDE CITY LIMITS?</span> <span style="font-size: 1.2em;">Maryland YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">3103 Belair Rd.-21213</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Nov. 9, 1896</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">73</span>	<b>If Under 1 Yr.</b> <span style="margin-left: 20px;">If Under 24 Hrs.</span> <small>Months; Days; Hours; Min.</small>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Guard</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Four Roses Distillery</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Balto. Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Oliver Hazard</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Elizabeth McMahon</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-09-9237</span>			<b>17. INFORMANT</b> <span style="margin-left: 20px;">ADDRESS</span> <span style="font-size: 1.2em;">Mrs. Anna Hazard - 3103 Belair Rd.-21213</span>		
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <small>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</small>   <b>ANTECEDENT CAUSES</b>  <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Cardiac arrest.</span>  <small>DUE TO, OR AS A CONSEQUENCE OF:</small>   <b>(B)</b> <span style="font-size: 1.2em;">Acute MI.</span>  <small>DUE TO, OR AS A CONSEQUENCE OF:</small>   <b>(C)</b> </div> </div>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <input type="checkbox"/> <small>(nativ medical examined)</small>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> <small>(If in Baltimore City, give exact location)</small>			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> <small>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/></small>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2/24</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/24</span> 19 <span style="font-size: 1.2em;">70</span>, that (2) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/24</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Tzen-chi Fan-Chiang</span>				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">TZEN-CHI FAN-CHIANG</span>				<b>23D. ADDRESS</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3-27-70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 30 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">John C. Miller Inc.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="margin-left: 20px;">ADDRESS</span> <span style="font-size: 1.2em;">6415 Belair Rd.-21206</span>			



# FUNERAL DIRECTOR: IMPORTANT

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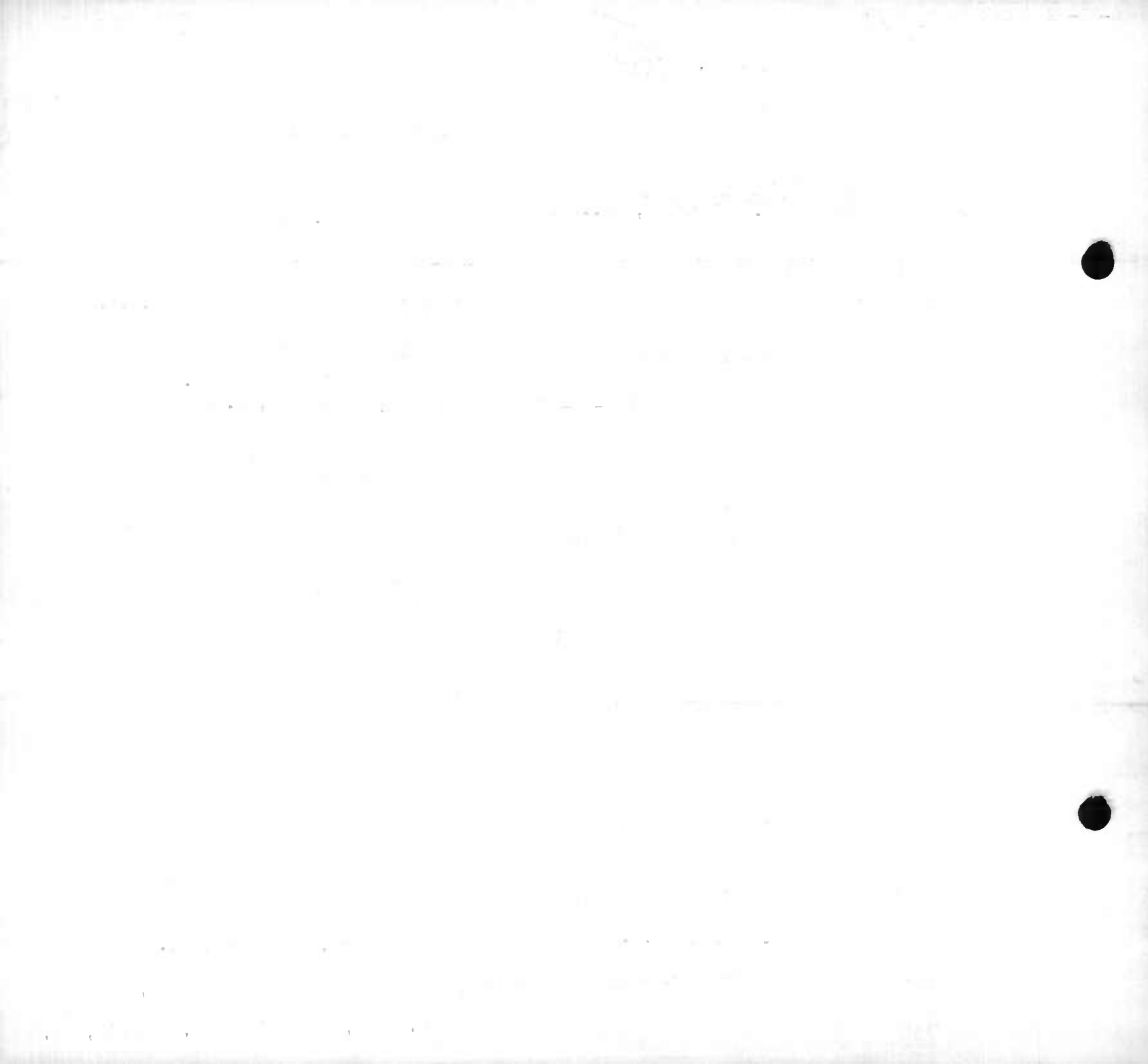
C-452		70 3291		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3291	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>William Clinan</u>			
2. DATE AND HOUR OF DEATH <u>3/24/70 12<sup>15</sup> A</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto. Co.</u>				5. SEX <u>Male</u> 6. RACE <u>White</u>			
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>			
E. STREET AND NUMBER <u>8112 Philadelphia Rd. Balto., Md. 21237</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11-17-13</u> 9. AGE (In years last birthday) <u>56</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Norman Clinan</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Davis</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W.II</u>				16. SOCIAL SECURITY NO. <u>230-03-7241</u>			
17. INFORMANT <u>4940 Eastern Avenue</u>				18. <u>340X</u> I CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <u>Cardiopulmonary arrest</u>				<u>3 days</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Sm. leg. Septicemia</u>				<u>6 days</u>			
(C) <u>Multiple Sclerosis</u>				<u>7 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1959</u> to <u>3/24 1970</u> that (I) (we) last saw the deceased alive on <u>3/23 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lynne I. Neefe</u>				23B. DATE SIGNED <u>3/24/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Lynne I. Neefe, M.D.</u>	
23D. ADDRESS <u>4940 Eastern Ave. Balto., Md. 21224</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-26-1970</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>				24D. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	
				ADDRESS <u>7401 Belair Road</u>		<u>21236</u>	



## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		70 3292	
BIRTH NO. 3-143 70 3292				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Maggie M. Shiflett				2. DATE AND HOUR OF DEATH 3/25/70 1 250 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3 Baltimore City Hospital				A. STATE B. COUNTY Maryland Baltimore			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 4940 Eastern Ave. Baltimore, Md..21224				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-21-06	
11. BIRTHPLACE (State or foreign country) Virginia				9. AGE (In years last birthday) 63		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charley Roberts			
14. MOTHER'S MAIDEN NAME Virgie Sullivan				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-26-7234				17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE cardiac arrest			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Acute respiratory insufficiency			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				DUE TO, OR AS A CONSEQUENCE OF:			
(C) COPD, Prob pulm embol				24 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic CHF			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-23 19 70 to 3-25 19 70 that (I) (we) last saw the deceased alive on 3-25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ronald G. Haller M.D.				23B. DATE SIGNED 3/25/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Ronald G. Haller M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/70		24C. NAME OF CEMETERY OR CREMATORY Chesnut Grove Baptist Church		24D. LOCATION (City, town, or county) (State) Earlyville, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Baker		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-250		70 3293		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 70 3293	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH AIKEN				2. DATE AND HOUR OF DEATH 3/25/70 2.15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto. 5300				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals: 4940 Eastern Avenue Baltimore, Maryland 21224				E. STREET AND NUMBER 4940 Eastern Avenue, Baltimore City Hospitals 21224			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-10-1898	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Harrison				14. MOTHER'S MAIDEN NAME Cassie E. Seward					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-0782-B		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224				ADDRESS	
18. 5-69-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Prob. upper gi. bleed DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Rheumatoid arthritis, sacral decubiti, uterine prolapse									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/9 1968 to 3/25 1970, that (I) (we) last saw the deceased alive on 3/25/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE C. Krush				DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/25/70			
23C. PHYSICIAN'S NAME (Type) C. Krush				23D. ADDRESS Baltimore City Hospitals 21224 4940 Eastern Avenue, Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-70		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Dorsey, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			

1228 Beechwood Rd 21219.

From Hospital CT

110



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

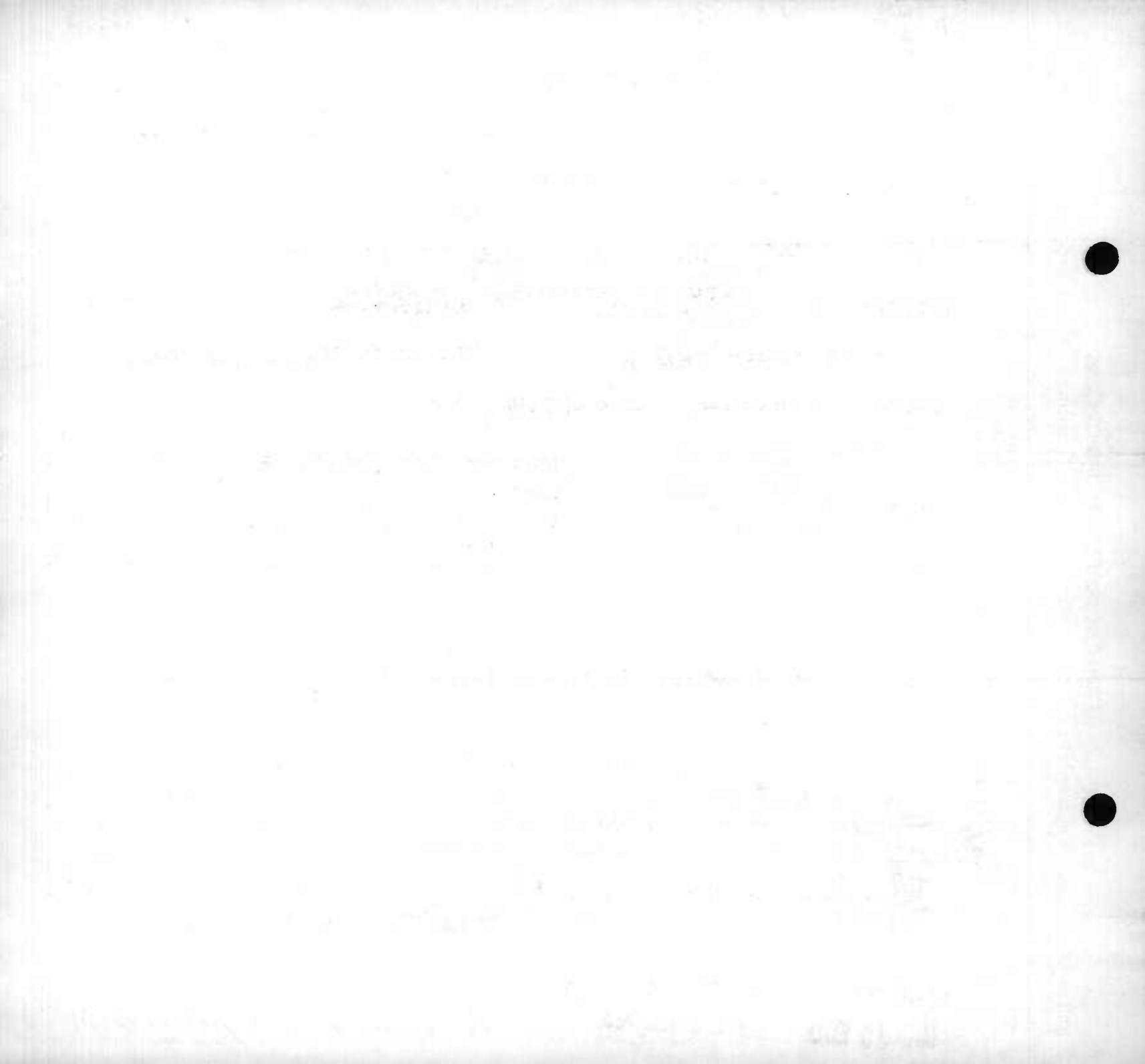
B-432 70 3294				BALTIMORE CITY HEALTH DEPARTMENT		70 3294	
BIRTH NO.				REG. NO.		70 3294	
1. NAME OF DECEASED (Type or Print) <b>Francisco Baltazar Jr</b>				2. DATE AND HOUR OF DEATH <b>3-27-70 10:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Univ of Md. Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2644</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Univ of Md. Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5409 Sarril Rd apt A</b>			
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-40</b>	9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Church Home Hospital Philippines</b>		12. CITIZEN OF WHAT COUNTRY? <b>PHILIPPINE Is.</b>	
13. FATHER'S NAME <b>Francisco Baltazar</b>				14. MOTHER'S MAIDEN NAME <b>Bura Anastacio</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-52-2007</b>		17. INFORMANT ADDRESS <b>Rodelio M. Lim M.D. 5409 Sarril Road</b>	
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Berry aneurysm (vs a.v. malformation)</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (t) (this hospital) attended the deceased from <b>Mar 26 1970</b> to <b>Mar 27 1970</b> that (t) (we) last saw the deceased alive on <b>Mar 27 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Paul R. Spilsbury M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-27-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>PAUL R. SPILSBURY. M.D.</b>				23D. ADDRESS <b>Univ. of Md Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Apr. 1. 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Manila</b>		24D. LOCATION (City, town, or county) (State) <b>Manila Philippine</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS INC. 1649 East North Ave. Balto. Maryland</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3295	
BIRTH NO.				Registered No.	
M.E. CASE NO.				7-524 70 3295	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
LEWIS FANSLAN				3-27-70 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
MARYLAND GENERAL HOSPITAL		BALTIMORE MD. BALTIMORE 1205		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BALTIMORE GENERAL HOSPITAL		BALTIMORE CITY		D. STREET ADDRESS (If rural, give location)	
1800 N. CHARLES ST.		5. SEX		6. RACE	
M		W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
DIVORCED		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
6-29-12		57		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DETECTIVE		BURNS DETECTIVE AGENCY		MARYLAND UNKNOWN	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME	
U.S.A.				UNKNOWN JOHN h	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
YES UNKNOWN				220-01-3614	
17. INFORMANT				ADDRESS	
PATIENT				UNKNOWN ROSETTA BETZ	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				20 MIN	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) MASSIVE ASPIRATION & CARDIO-PULMONARY ARREST	
ANTECEDENT CAUSES				(B) Perforated peptic ulcer and gallbladder	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CHRONIC EMPHYSEMA	
II				5 weeks YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				MEDICAL CERTIFICATION	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12-28-70		Perforated ulcer gallbladder		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 24, 1970 to MARCH 27, 1970, that (I) (we) lost saw the deceased alive on MARCH 27, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Charles S. Harrison		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		3-27-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
M.D. MARYLAND GENERAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify)			
BURIAL		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
3-30-70		OAK LAWN		24D. LOCATION (City, town, or county) (State)	
BALTO. CO. Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAR 30 1970		John E. Taylor, M.D.		25C. FUNERAL DIRECTOR	
ADDRESS		W. Brinkley, Hurdock, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

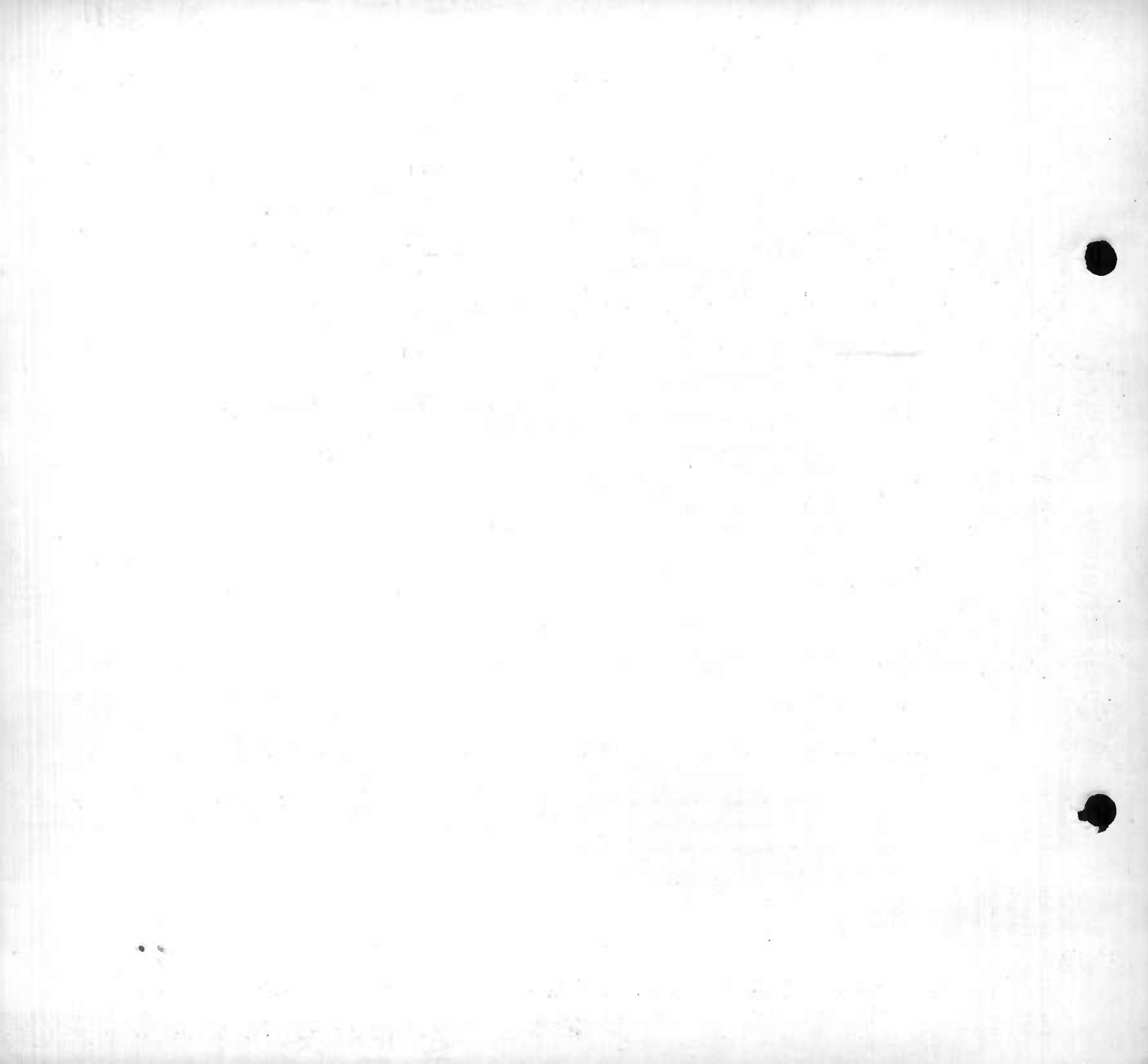
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. 70 3296											
BIRTH NO. 70 3296		1. NAME OF DECEASED (Type or Print) <b>MARTIN ZNAMIROWSKI</b>									
		2. DATE AND HOUR OF DEATH <b>MARCH 24 1970 7:30 A.M.</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE <b>MARYLAND</b>						
<b>00 523 S. LAKEWOOD AVE</b>					B. COUNTY <b>0103</b>						
					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <b>523 S. LAKEWOOD AVE</b>						
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 11 1890</b>		9. AGE (In years last birthday) <b>79 yrs</b>			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>FOWLER CO.</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>MICHAEL</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>214-16-8382</b>		17. INFORMANT <b>MRS. PAULINE ZNAMIROWSKI</b>		ADDRESS <b>SAME</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA OF THE LUNGS</b>					<b>6 MONTHS</b>	
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO, OR AS A CONSEQUENCE OF:						
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JANUARY 13 1970</b> to <b>MARCH 24 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>MARCH 22 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <b>Melito M. Torres, M.D.</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>MARCH 25, 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>MELITO M. TORRES, M.D.</b>					23D. ADDRESS <b>441 S. ELLWOOD AVE, BALTO, MD 212</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/28/70</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. STANISLAUS CEM.</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR <b>RAYMOND A. KACZOROWSKI</b>			ADDRESS <b>2525 FLEET ST.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3297</b>	
BIRTH NO. <b>70 3297</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>SALEM NAMETAK</b>		2. DATE AND HOUR OF DEATH <b>3-23-70</b>		8:20 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>0103</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>3.3</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2442 FOSTER AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-14</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PATTERN MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FLYNN + EURICH</b>		11. BIRTHPLACE (State or foreign country) <b>YUGOSLAVIA</b>	
13. FATHER'S NAME <b>MEHMET NAMETAK</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. JOHANNA M. NAMETAK</b>	
				ADDRESS <b>2442 FOSTER AVE.</b>	
18. <b>185</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMATOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>BLADDER CA.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BLADDER CA.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2/20/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PAIN</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> 19 <b>70</b> to <b>3/23</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward R. Laws Jr</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>3/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD R. LAWS JR</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>3/26/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK CEMETERY</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>RAYMOND LEON KACZOROWSKI</b>	
				ADDRESS <b>2525 Fleet St</b>	





M-240

70

3298

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3298

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Juanita Mackall</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 25 70 10:05 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>		3. DATE PRONOUNCED DEAD Month Day Year <u>March 25, 1970</u> 10:05 a. M.	
6. SEX <u>Female</u>		7. RACE <u>Negro</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>5-15-31</u>		10. AGE (In years last birthday) <u>38</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Hezekiah Harrison</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>none</u>	
18. INFORMANT		ADDRESS	
19. <u>912X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Aspiration of denture</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
22D. TIME OF INJURY (APPROX.) 3 24 70 9-9:30		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>713 Newington Ave. 1302</u>		22F. HOW DID INJURY OCCUR? <u>Subject aspirated dentures</u>	
21. AUTOPSY? (Yes or No) <u>YES</u>			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Isidore Mihalakis, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>3/25/70</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-28-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Gwainwright</u>		ADDRESS <u>2700 Edmondson Ave</u>	

ACADEMY OF MUSIC

WILLIAM T. PATERSON

Donor's Name

Address

City

State

Zip

Phone

Occupation

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3299</span>	
BIRTH NO. <span style="font-size: 1.5em;">B-622 70 3299</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LOVIE BURGESS</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">March 26, 1970</span> <span style="float: right;">1:45 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">00</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">602 N. AUGUSTA AVE.</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">602 N. AUGUSTA AVE.</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">COLORED</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">OCT. 5, 1902</span>	9. AGE (In years, lost birthday) <span style="font-size: 1.2em;">67</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">RITTER, S. C.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">DANIEL PADGETT</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ADELI ?</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MARY F. WILLIAMS - 602 N. AUGUSTA AVE.</span>	
18. <span style="font-size: 1.5em;">412.21</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">HCDV WITH CONGESTIVE FAILURE</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">SAME</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">None</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4-Weeks</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>He</del> <span style="font-size: 1.2em;">She</span> ) attended the deceased from <span style="font-size: 1.2em;">2/13/60</span> 19 <span style="font-size: 1.2em;">60</span> to <span style="font-size: 1.2em;">3/23/70</span> 19 <span style="font-size: 1.2em;">70</span> and that (I) ( <del>was</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">3/23</span> 19 <span style="font-size: 1.2em;">70</span> and that (in my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <span style="font-size: 1.2em;">March 26, 1970</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. PRESTON GRANT, M.D.</span>			23D. ADDRESS <span style="font-size: 1.2em;">601 N. CARROLLTON AVE.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">3-31-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">ST. PAUL</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">RITTER, S. C.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 30 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">CHARLES R. LAW 802 MADISON AVE., BALTO., MD.</span>	

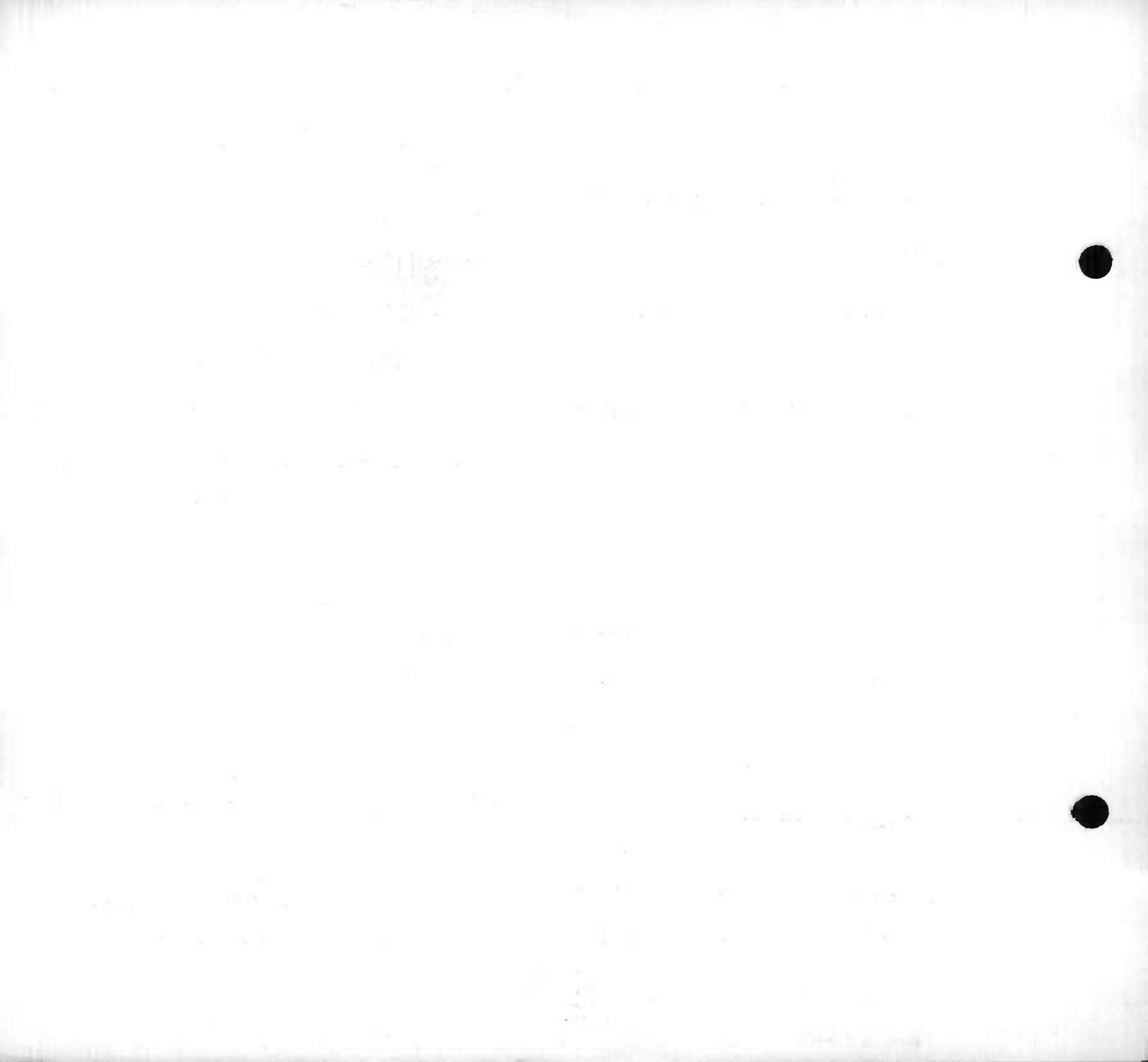


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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X-420 70 3300		BALTIMORE CITY HEALTH DEPARTMENT		X 70 3300	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>FERDINAND ALBERT KLAUS</b>		2. DATE AND HOUR OF DEATH <b>3/27/70 1 5<sup>15</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPHS HOSPITAL</b> <b>1800 WYMAN PARK DRIVE</b>		A. STATE <b>B. COUNTY</b> <b>SPRING GROVE HOSPITAL 5300</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>BALTIMORE, MD</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1918</b>	9. AGE (in years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PATIENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PATIENT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FERDINAND J. KLAUS</b>		14. MOTHER'S MAIDEN NAME <b>LIDAE HOFFMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>508-07-703</b>		17. INFORMANT ADDRESS <b>MEDICAL RECORDS-USPHS HOSPITAL</b>	
18. <b>1970-8-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] <b>CAUSE OF DEATH</b> <b>CARCINOMA OF LIVER (suspected)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>#10 ATRIAL FIBRILLATION</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(suspected)</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>#10 ATRIAL FIBRILLATION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotify medical examiner <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month) 1 Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>MARCH 19, 1970</b> to <b>MARCH 27, 1970</b> and that (1) (we) last saw the deceased alive on <b>MARCH 27, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph R. Martire MD</b>		23B. DATE SIGNED <b>3/27/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH R. MARTIRE, MD</b>		23D. ADDRESS <b>USPHS HOSPITAL, BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar 30/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baldwin</b>	
24D. LOCATION <b>Baldwin</b>		24E. CITY, town, or county <b>Baldwin</b>		24F. STATE <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Philip Hervey</b>		25C. FUNERAL DIRECTOR <b>Philip Hervey</b>	
25D. ADDRESS <b>2024</b>					



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A-163

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3301

BIRTH NO. 70-02529

1. NAME OF DECEASED (Type or Print) MARSELLE L. AVERETTE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD March 28, 1970 4:55 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802	
9. DATE OF BIRTH 2-10-70		10. AGE (In years lost birthday) 1 1/2	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willis L. Averette		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Debrah Kirksey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Debrah Averette 1717 Montford Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-28-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/70	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	



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Miller .  
Robert .

2-20-70  
Maryland

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3302</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3302</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>Wormblyg Rutha</i>			2. DATE AND HOUR OF DEATH <i>3-28-70 11:06 P. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1604</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Dukeland Nursing Home</i> <i>90 1501 N. Dukeland St.</i>			C. CITY OR TOWN <i>Baito.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>F</i> 6. RACE <i>N W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>3-5-89</i>		9. AGE (In years last birthday) <i>91</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>West Point, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>C. S. A.</i>
13. FATHER'S NAME <i>Joseph Nelson</i>			14. MOTHER'S MAIDEN NAME <i>Linda Nelson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>228-32815</i>		17. INFORMANT <i>Dukeland Nursing Home</i>
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>HACVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1966</i>
(B) <i>Diabetes mellitus</i> DUE TO, OR AS A CONSEQUENCE OF:			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 8 1966</i> to <i>3-28 1970</i> , that (I) (we) last saw the deceased alive on <i>3-28 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas W. Harris</i>				23B. DATE SIGNED <i>3-29-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>THOMAS W. HARRIS</i>		23D. ADDRESS <i>4200 EDMONDSON AVE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>4-3-1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>Rolling Green Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>West Chester, Chester, PA</i>		25A. DATE AND HOURS OF DEATH <i>MAR 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Wm C MARCH</i>		25D. ADDRESS <i>908 E. North Ave</i>			

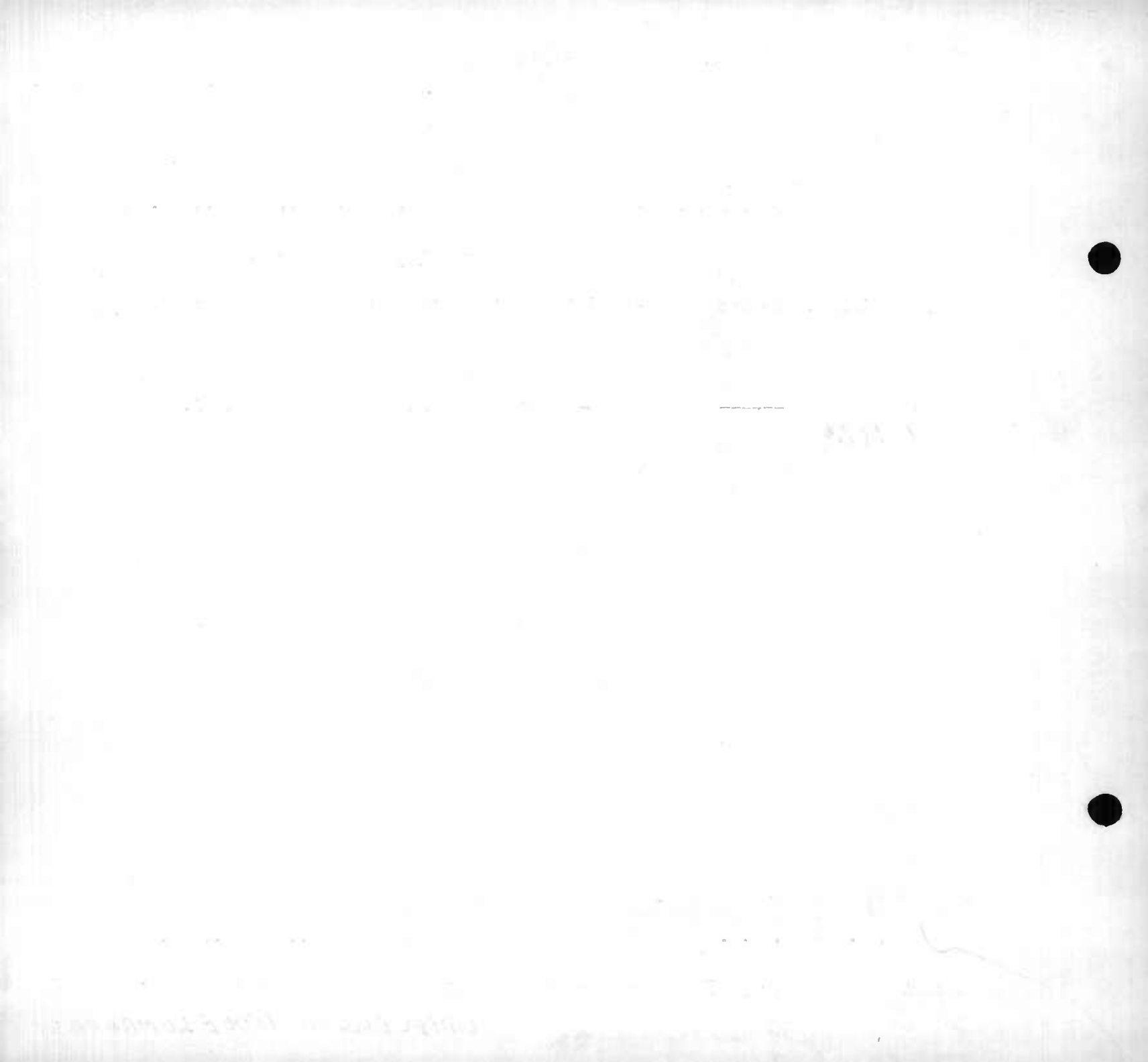
617 N. Brice St

called N.H. CT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

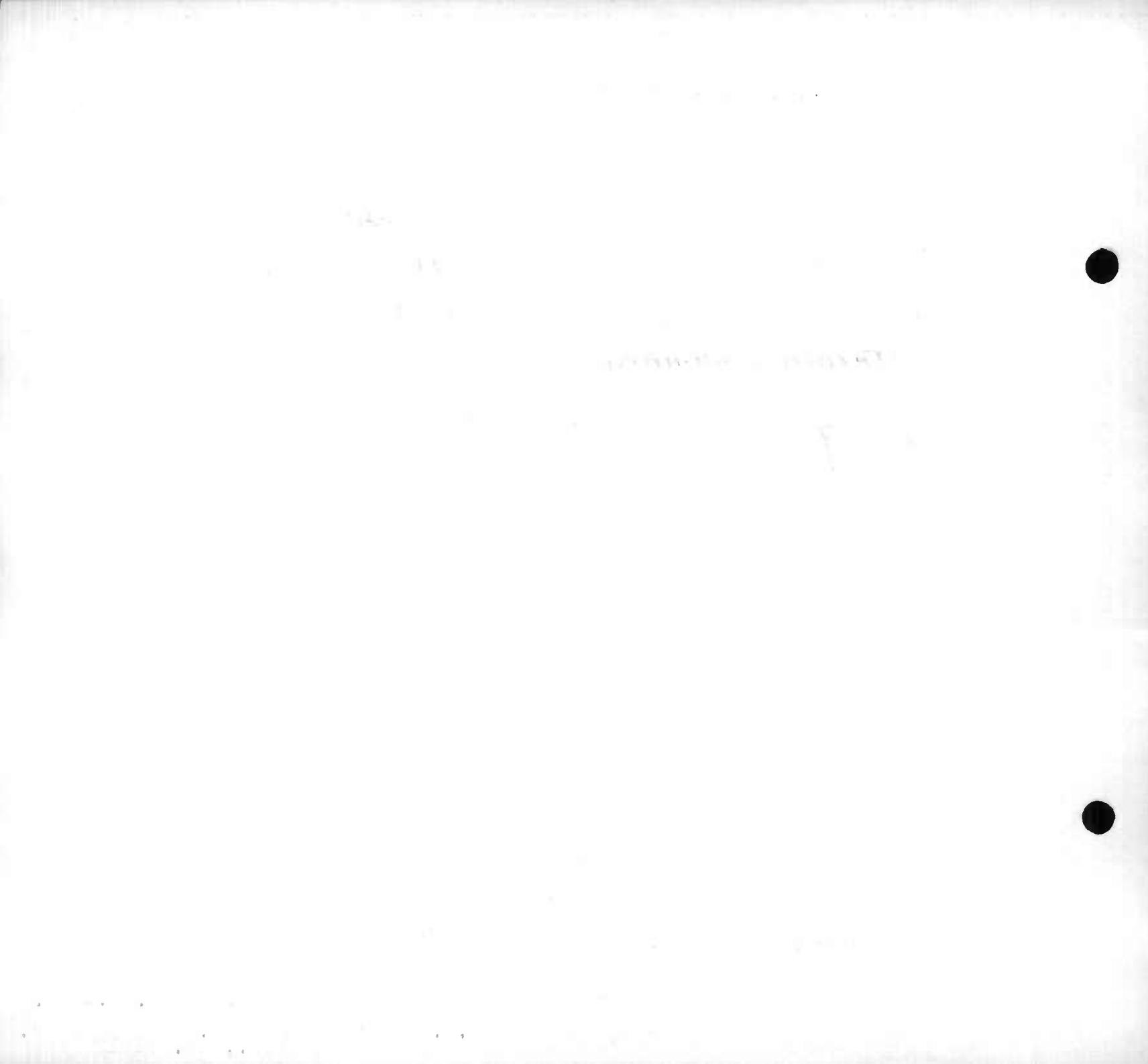
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3303</b>	
70 3303		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED <b>Franz Unbanowicz</b> <i>FRANZ ZEK</i>		2. DATE AND HOUR OF DEATH <b>3-27-70</b> <b>10 P.M.</b>	
(Type or Print)		<i>Erasmus + Aug</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>Baltimore City Hospital</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Md. 21224</b>			A. STATE <b>Maryland</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>621 S. Wolfe St., Balto., Md. 21231</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1890</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Knipp &amp; Co Inc</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>UNK</b>			14. MOTHER'S MAIDEN NAME <b>UNK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>210-26-0706</b>	17. INFORMANT ADDRESS <b>4940 Eastern Avenue</b> <b>BCH Records: Baltimore, Md. 21224</b>		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>respiratory arrest</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>atrial fibrillation, (R) inguinal hernia, cellulitis</b>					
19A. DATE OF OPERATION <b>2/25/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Benign prostatic hypertrophy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/27/70</b> to <b>3/27</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C. Krush M.D.</b>			23B. DATE SIGNED <b>3/27/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>C. Krush, M.D.</b>			23D. ADDRESS <b>Baltimore City Hospital</b> <b>4940 Eastern Ave., Balto., Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar 31 70</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>German Hill Road Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>DIPPEL BROS INC 1800 E LOMBARD ST</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

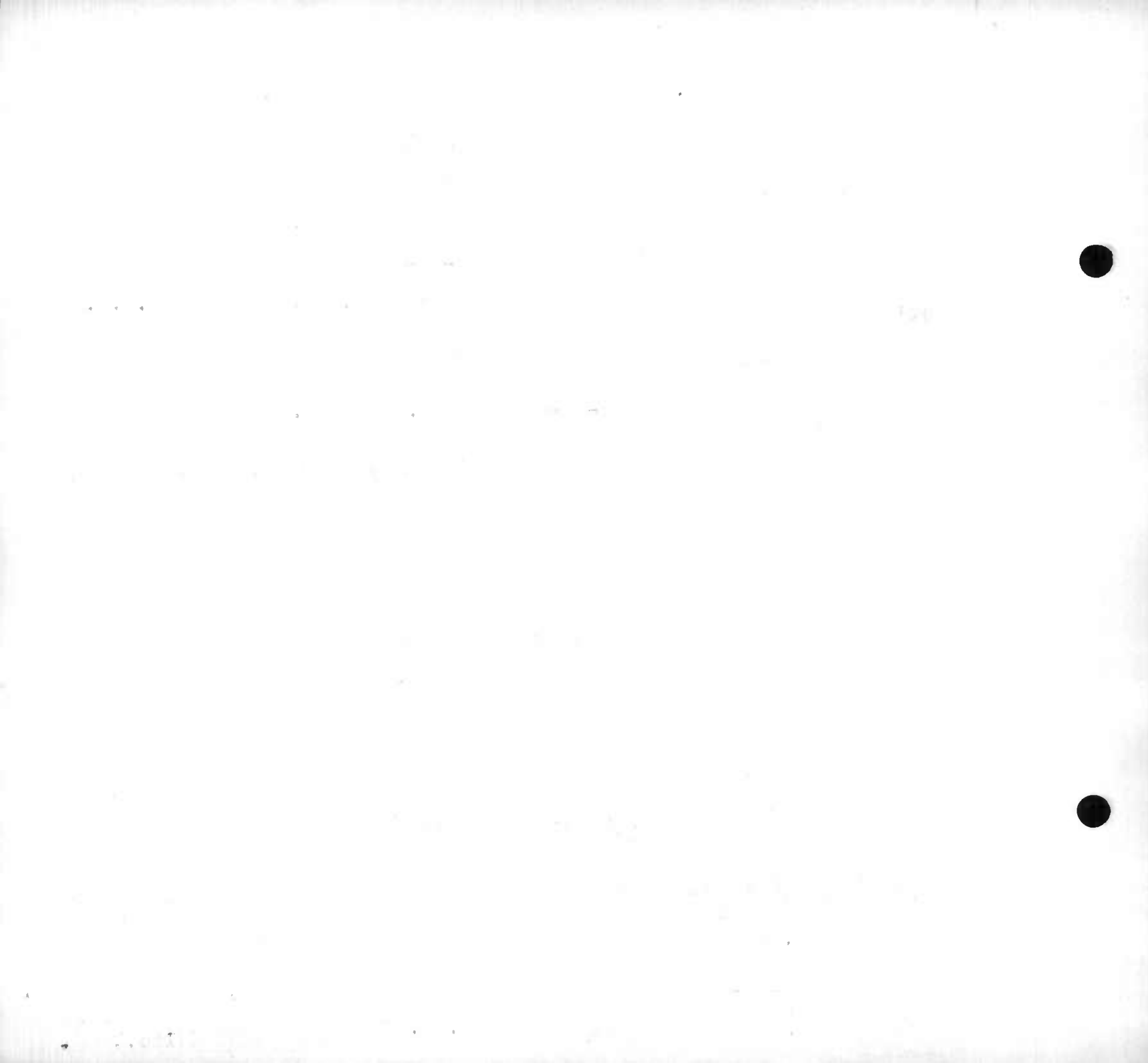
BALTIMORE CITY HEALTH DEPARTMENT				70 3304		REG. NO. 70 3304	
BIRTH NO.		70 3304		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>RICHARDS HELEN WILLIAMS</b>				2. DATE AND HOUR OF DEATH <b>3-29-70 10:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>902</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1651 SHADYSIDE ROAD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>06-27-92</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS RICHARDS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA McCALL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-2545A</b>		17. INFORMANT <b>JOHN E. WILLIAMS</b>		ADDRESS <b>(SAME)</b>	
18. <b>4-11-70 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY INSUFFICIENCY - CARDIAC ARREST.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>03-27-70</b> 19 to <b>03-29</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>03-29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Enlavarront</b>				23B. DATE SIGNED <b>03-29-70</b>		23C. PHYSICIAN'S NAME (Type) <b>EVELYN P. NAVARRO</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3305</u>	
BIRTH NO. <u>70 3305</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Frank H. Zeichner</u>			2. DATE AND HOUR OF DEATH <u>March 28, 1970</u> <u>4:30 p.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1557 Sheffield Road</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2759</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1557 Sheffield Road</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1892</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Union Hill, New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Carl Wilhelm Zeichner</u>		
14. MOTHER'S MAIDEN NAME <u>Elsie Sophie Tjarks</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-07-2997</u>		17. INFORMANT <u>Mrs. Frank H. Zeichner</u>		ADDRESS <u>Same</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>PARKINSON'S DISEASE</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>A.S.C.V. DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>  <u>YEARS(?)</u>  <u>YEARS(?)</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 24, 1970</u> to <u>MARCH 28, 1970</u> that (I) (we) last saw the deceased alive on <u>MARCH 28, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arthur Karfgin M.D.</u>			23B. DATE SIGNED <u>3/30/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Arthur Karfgin</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3-31-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>			25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Son Co.</u>		
25D. ADDRESS <u>4505 York Road Balto., Md.</u>			25E. ADDRESS <u>21212</u>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3306	
BIRTH NO. 70 3306		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SIMPSON, ANNA M</b>		2. DATE AND HOUR OF DEATH <b>3/29/1970 5.05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3604 REXMERE ROAD</b>					
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/1906</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA (AMERICAN)</b>					
13. FATHER'S NAME <b>LAUCKEY, CHARLES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET HORSTMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>800-01-7044</b>		17. INFORMANT <b>WILLIAM L. SIMPSON</b>	
18. <b>153.8</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF COLON WITH LIVER METASTASIS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/7/1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/25</b> 19 <b>70</b> to <b>3/29</b> 19 <b>70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/29</b> 19 <b>70</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Kasuke Tsujimoto, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/29/1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>KASUKE TSUJIMOTO, M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL 33RD + CALVERT STS. BALTIMORE Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>4-1-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount</b>	
24D. LOCATION <b>Baltimore</b>		24E. (City, town, or county) (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>	
25D. ADDRESS <b>4905 York Road Balto., Md. 21212</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3307</u>	
BIRTH NO. <u>70 3307</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARY E. ENSOR</u>			2. DATE AND HOUR OF DEATH <u>3/26/70</u> <u>11:00 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>MARYLAND</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2629 Guilford Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/80</u>	9. AGE (In years last birthday) <u>90</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookkeeper</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>W.E. ARNOLD CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>JACOB ENSOR</u>		
14. MOTHER'S MAIDEN NAME <u>MARtha HAINES</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-09-3629A</u>			17. INFORMANT <u>EUGENE ENSOR</u> ADDRESS <u>SAME</u>		
18. <u>736.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION <u>01/17/70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>for</u>		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1/15/70</u> 19 <u>70</u> to <u>3/26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/26</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> <u>H.D.</u> DEGREE			23B. DATE SIGNED <u>3/26/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>CARLOS E. FOSSI</u> <u>H.D.</u> DEGREE			23D. ADDRESS <u>UNION MEMORIAL Hospital</u>		
24A. BURIAL-CREATION, REMOVAL (Specify)	24B. DATE <u>3-30-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber, M.D.</u>	25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-420		70 3308		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3308	
1. NAME OF DECEASED (Type or Print) FANNIE ELLIS				2. DATE AND HOUR OF DEATH MARCH 23, 1970 1:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Wed.</u> B. COUNTY <u>1506</u>			
5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Aug 1, 1886</u> 9. AGE (In years last birt) <u>84</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Loving</u>				14. MOTHER'S MAIDEN NAME <u>Anna Loving</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				6. SOCIAL SECURITY NO.		17. INFORMANT <u>Belle Minn</u> ADDRESS <u>2930 W. North Ave</u>	
18. 56211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. DIVERTICULOSIS OF THE DESCENDING COLON				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>MARCH 16, 1970</u> to <u>MARCH 23, 1970</u> , that <u>we</u> last saw the deceased alive on <u>MARCH 23, 1970</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (We) (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <u>Christos Dibrans, M.D.</u> DEGREE				23B. DATE SIGNED <u>MARCH 23, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>CHRISTOS DIBRANS, M.D.</u> DEGREE	
23D. ADDRESS <u>730 ASHBURTON STR., BALTO., MD. 21216</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>3-26-70</u> 24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cem</u> 24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>				25C. FUNERAL DIRECTOR <u>Rayner Sanders</u> ADDRESS <u>217 E. Preston St</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 10-630		370 3309		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 3309	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Elizabeth WARD				2. DATE AND HOUR OF DEATH 3/27/70 2:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Md 21202				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 301 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 26 N. Bond Street			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7/4/00	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-1782		17. INFORMANT ADDRESS Records Of Midtown Home, Inc. 808 St Paul St.			
18. 225.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Cardio Respiratory Failure Possible Meningioma (B) DUE TO Cerebral Vascular Accident (C) Chn. Brain Syndrome INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 25 1968 to Mar 27 1970 that (I) (we) last saw the deceased alive on Mar 27 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE William D. Appleford M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) William D. Appleford M.D.				23D. ADDRESS 6615 Rockersham rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/70		24C. NAME of CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS Station Dr Wilson 1913 W Belts	

Order of the  
Board of Directors  
of the  
City of New York

June 28, 1912

Resolved, That the  
City of New York



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3310</u>	
BIRTH NO. <u>H-620</u>				70 3310	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Bessie Harris				March 26, 1970 4:00 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland B. COUNTY 1601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Carroll Nursing Home 822 N. Carrollton Avenue	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-26-83	
13. FATHER'S NAME Milton Barnes		14. MOTHER'S MAIDEN NAME Laura Brown		9. AGE (in years last birthday) 77 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-8478		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Mrs. Clara Hardesty/Friend		ADDRESS 612 N. Carey St.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 1519 Metastatic Ca of stomach (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 25, 1970 to March 26, 1970 that (I) (we) last saw the deceased alive on March 26, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.D. <i>[Signature]</i> DEGREE				23B. DATE SIGNED 3-26-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/30/70		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park Cem.	
24D. LOCATION Arbutus Balto. M		25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Stetson B. Wilson Funeral Home 1913 W. Balto. St.			

called FUNERAL Director Address  
is 1217 W. Lafayette Ave.

# FUNERAL DIRECTOR: IMPORTANT

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B-640 70 3311		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3311	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN BURLEY</b>		2. DATE AND HOUR OF DEATH <b>3/26/70 2:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1304</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MONTEBELLO STATE HOSPITAL</b>		E. STREET AND NUMBER <b>2218 Whittier ave 21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1907</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Flourine Stewart</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-16-4818</b>		17. INFORMANT ADDRESS <b>Montebello State Hospital Record.</b>	
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Lung Carcinoma, left, metastatic. 1 years.</b> (B) <b>Breast C.A. Right. 3 years.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-30-1970</b> to <b>3-26-1970</b> that (I) (we) last saw the deceased alive on <b>3-26-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Fuxa</b>		23B. DATE SIGNED <b>3/26/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JORGE FUXA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Ch.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Washington S. Phillips</b>		25D. ADDRESS <b>1727 N. Meade</b>			



BIRTH NO.		1. NAME OF DECEASED (Type or Print)		AUTHOR BOARDLY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If in hospital or institution, give name of institution, street address or location)		3. DATE PRONOUNCED DEAD March 25, 1970		11:40 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1509	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6/9/1901		10. AGE (In years last birthday) 68		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 3812 Fairview Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Wesley Boardley		15. MOTHER'S MAIDEN NAME Lettie Clifford	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
19. 412.4		CAUSE OF DEATH		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) (Partial) Yes No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Springate, M.D.		DATE SIGNED March 26, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/30/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR		ADDRESS Arlington S. Phillips 1727 N. Mount	

VALLEY FOR

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3313</span>	
S-212 70 3313 <b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Sakievich), <i>Sakievich Veronica</i>		2. DATE AND HOUR OF DEATH <i>3/26/70 1:15</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Street Nursing Home 901213 Light Street</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>4819 Pleasant View Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1895</i>	9. AGE (In years lost birthday) <i>74 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Unknown Matusевич</i>		
14. MOTHER'S MAIDEN NAME <i>Unknown</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>2 16-05-2819</i>			17. INFORMANT <i>Mr. George Sakievich</i>		
18. ADDRESS (Same)			19. CAUSE OF DEATH		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <i>Generalized arteriosclerosis</i>		
			<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>chronic urinary tract infection</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/18</i> 19 <i>70</i> to <i>3/27</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Arthur Rosenfeld MD</i>				23B. DATE SIGNED <i>3/27/60</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Harbor View Nursing Home</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/30/70.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			

Nov. 20, 1961

11

(over)

J. George Johnston

George Johnston, Jr., 1961



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

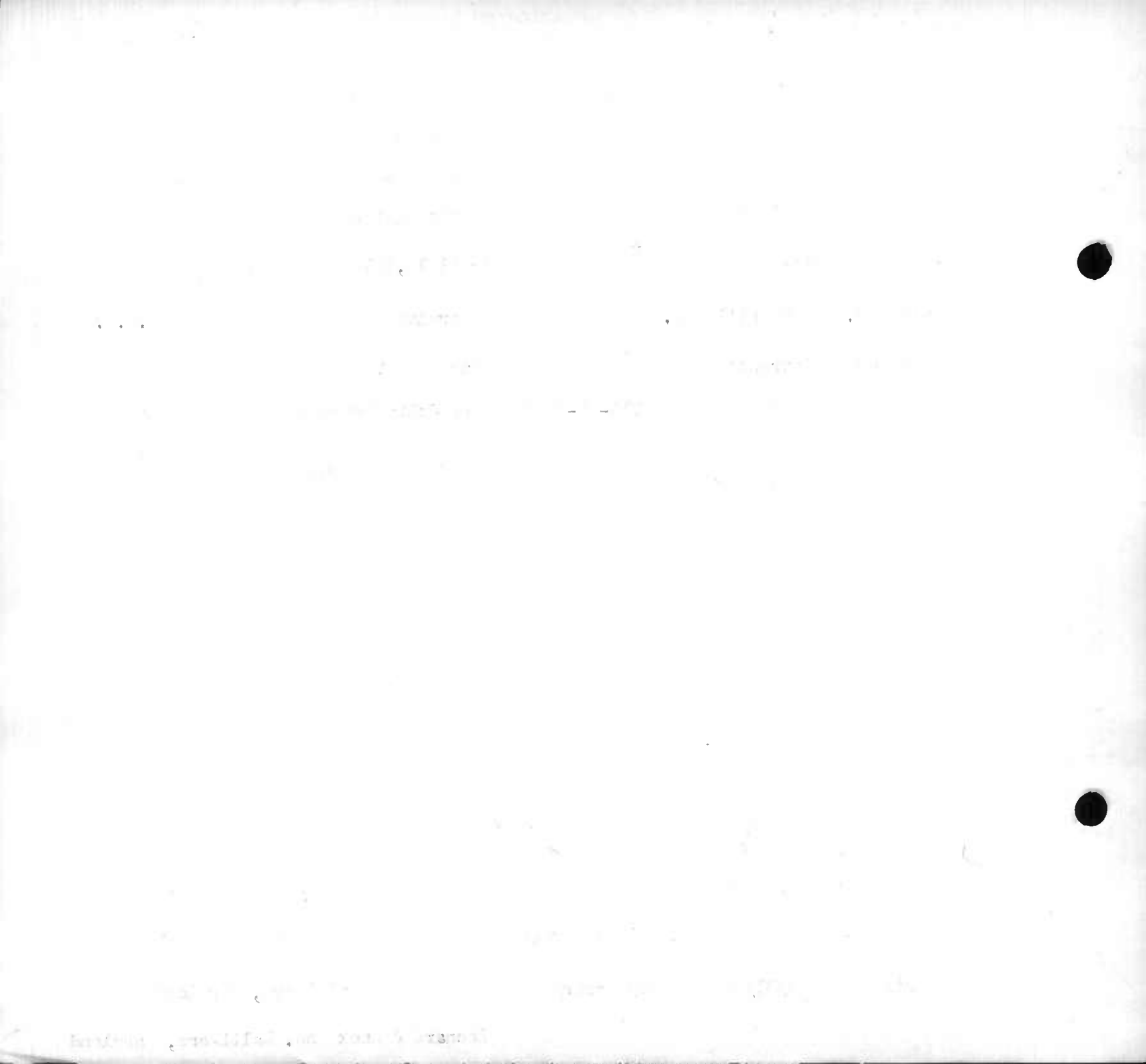
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
R-355 70 3314		70 3314		70 3314	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		E. J. REDMOND Bernard (Redmond)		2. DATE AND HOUR OF DEATH Mar. 27, 1970 12:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1902			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		US Public Health Service Hospital 3100 Wyman Parkway		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1323 W. Lombard St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/13	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Phillip H. Redmond			14. MOTHER'S MAIDEN NAME ? Mary Brewer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-3444		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Pulmonary insufficiency (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Tuberculosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar. 25 1970 to Mar. 27 1970, that (I) (we) last saw the deceased alive on Mar. 27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE Donald E. Beaulieu				23B. DATE SIGNED 3/27/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/31/70.		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 3315</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Lee</span> <span style="font-size: 1.2em;">Joseph Lawrence</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/27/70</span> <span style="font-size: 1.2em;">1:05</span> AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2642</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">4321 Sheldon Ave</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">April 16, 1910</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">59</span>	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Claim Mgr. Penna Nat'l Ins. Co</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Joseph L Lawrence</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mae ?</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WW 11</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-05-9688</span>			17. INFORMANT <span style="font-size: 1.2em;">Mrs Julia Lawrence</span> ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">238.1 I</span> <span style="font-size: 1.2em;">Right cerebellar tumor</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-25-1970</span> to <span style="font-size: 1.2em;">3-27-1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-27-1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">C. V. Limar, MD</span> DEGREE				23B. DATE SIGNED <span style="font-size: 1.2em;">3-27-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CONSTANTINOS V. LIMAR, MD</span> DEGREE				23D. ADDRESS <span style="font-size: 1.2em;">Mercy Hosp. BALTO, MD</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/31/70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Rosary</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 30 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck Inc.</span> ADDRESS <span style="font-size: 1.2em;">Baltimore, Maryland</span>			



# FUNERAL DIRECTOR: IMPORTANT

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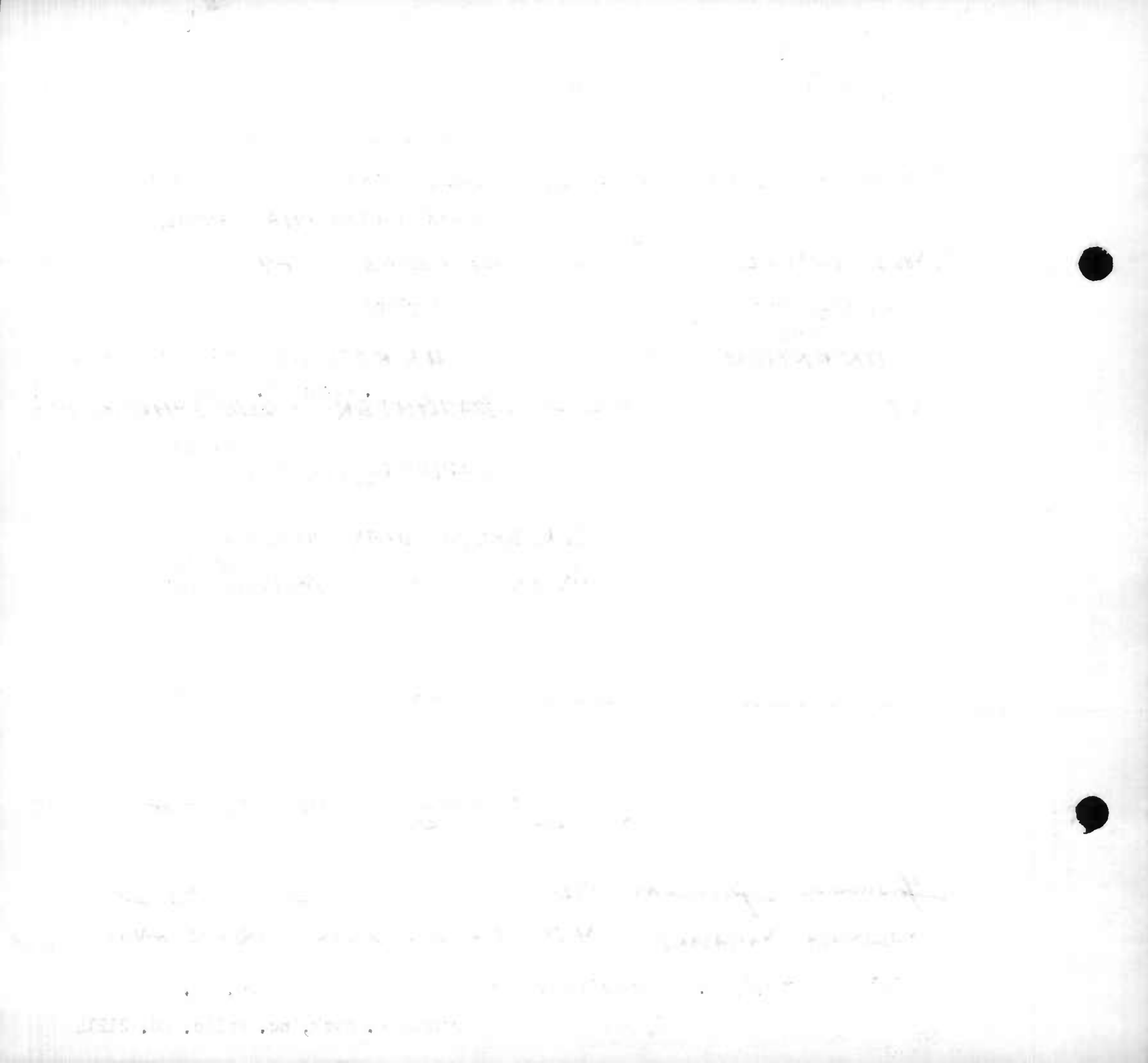
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3316</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">B-653</span> <span style="font-size: 1.5em;">70 3316</span> <span style="font-size: 1.5em;">70 3316</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BESSIE E. BRYANT</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-27-70</span> <span style="font-size: 1.2em;">9:40 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">HARRISVIEW NURSING HOME (1213 LIGHT ST.)</span> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">49 NORTH CHARLES GEN. HOSP.</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">1213 LIGHT ST.</span>		<span style="font-size: 1.5em;">2403</span>
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3-7-82</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">88</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Seamstress</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Erlangers Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VA. VIRGINIA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">FERDINAND DODSON</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY HAYDEN</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-03-3283</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Elizabeth Webster</span>	
				ADDRESS <span style="font-size: 1.2em;">3144 Woodring Ave.</span>	
18. <span style="font-size: 1.5em;">288X</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">SEPTIC SHOCK</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">MARKED LEUKOPENIA &amp; PNEUMONITIS</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) <span style="font-size: 1.2em;">DEHYDRATION &amp; GT BLEEDING</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">24-48 hrs.</span>  <span style="font-size: 1.2em;">?</span>  <span style="font-size: 1.2em;">24 hrs.</span>
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-26</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3-27</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-27</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Jose Y Ortiz M.D.</span>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">3-27-70</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOSE Y ORTIZ</span>			23D. ADDRESS <span style="font-size: 1.2em;">NORTH CHARLES GEN. HOSP.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/31/70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Farnham Baptist Church</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Richmond Co., Va.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 30 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck Inc. Balto. Md.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3317</u>	
F-224		70 3317		CERTIFICATE OF DEATH	
BIRTH NO. <u>70 3317</u>		1. NAME OF DECEASED (Type or Print) <u>ANNA D. FUCHSLUGER</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>03-28-70</u> <u>6.20 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>44</u>		E. STREET AND NUMBER <u>5218 CATALPHA ROAD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-02-03</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Francis Ruppel</u>		14. MOTHER'S MAIDEN NAME <u>Kunigunda Schmidt</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>220-12-6268</u>		17. INFORMANT <u>Mr. Joseph F. Fuchsluger</u> ADDRESS (Same) <u>BALTIMORE, MARYLAND</u>	
18. <u>412.3</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARDIO RESPIRATORY</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>03-22</u> 19 <u>70</u> to <u>03-28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>03-22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Yasumasa Yamasaki M.D.</u>		23B. DATE SIGNED <u>03-28-70</u>		23C. PHYSICIAN'S NAME (Type) <u>YASUMASA YAMASAKI M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3 4/1/70.</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-626 70 3318		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 3318	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>May C. Burkart</i>		2. DATE AND HOUR OF DEATH <i>March 29, 1970 4<sup>00</sup> P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hospital 133 E. + Calvert Sts.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1201</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		E. STREET AND NUMBER <i>3811 Canterbury Road</i>		F. CITY OR TOWN <i>Capitombury</i>	
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1900-5-26</i>	9. AGE (In years last birthday) <i>69</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Legal secretary</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John J. Burkart</i>		14. MOTHER'S MAIDEN NAME <i>Minna Schnepfe</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-9859</i>		17. INFORMANT <i>Mr. Lewis Burkart, 2917 Hillcrest Ave.</i>	
18. <i>1955-01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</i>		(A) IMMEDIATE CAUSE <i>resp. arrest</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>extensive abdom. carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>3-24-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>exploratory lapotomy</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-17-70</i> to <i>Mar 29 1970</i> that (I) (we) last saw the deceased alive on <i>Mar 28 1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Knudsen</i>		23B. DATE SIGNED <i>Mar 29, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Robert E. Taylor, M.D.</i>	
23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>		23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/1/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>LOUDON PARK CEMETERY</i>	
24D. LOCATION <i>BALTO. MD. 21229</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		24F. FUNERAL DIRECTOR <i>LEONARD J. RUCK, Inc. BALTO. MD. 21214</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 30 1970</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

5/27/70 - Correction form from ~~XXXXXX~~ funeral director.

*ABC.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3319</span>	
C-636 <span style="font-size: 1.5em;">70 3319</span>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VIOLET M. CARTER		March 27, 1970.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">00</span> 710 E. 33rd. Street			A. STATE <span style="font-size: 1.5em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">903</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.5em;">710 E. 33 rd. Street</span>		
5. SEX <span style="font-size: 1.5em;">Female</span>	6. RACE <span style="font-size: 1.5em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">July 26, 1896.</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">73</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Penna.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">Jack L. Timlin</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Rena Munn</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">218-07-6306</span>		17. INFORMANT <span style="font-size: 1.5em;">Mr. Clarence Carter</span> ADDRESS <span style="font-size: 1.5em;">(Same)</span>	
18. <span style="font-size: 1.5em;">412.3 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">ARTERIOSCLEROTIC HEART DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">39 YEARS.</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No.</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.5em;">12-12</span> 19 <span style="font-size: 1.5em;">69</span> to <span style="font-size: 1.5em;">12-31</span> 19 <span style="font-size: 1.5em;">69</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.5em;">12-31</span> 19 <span style="font-size: 1.5em;">69</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Anthony A. Lewandowski</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">3-30-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Anthony A. Lewandowski M.D.</span>				23D. ADDRESS <span style="font-size: 1.5em;">11 E. Chase Street</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">3/31/70.</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Dulaney Valley Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 30 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>			

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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3320</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 1.5em;">L-520</span>		1. NAME OF DECEASED <span style="font-size: 1.2em;">Eluid Rufus Laing</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/29/70 11:55 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <span style="font-size: 1.2em;">Md.</span>		B. COUNTY <span style="font-size: 1.2em;">2737</span>	
<span style="font-size: 1.2em;">90 Mt. Sinai Nursing Home 4613 Park Heights Ave.</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">M.</span>		6. RACE <span style="font-size: 1.2em;">W.</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">Aug. 29, 1892</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.2em;">Refrigeration Repairing</span>				<span style="font-size: 1.2em;">Va.</span>	
12. CITIZEN OF WHAT COUNTRY?		<span style="font-size: 1.2em;">U.S.A.</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">James M. Laing</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Spitzer</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">178-05-7314</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">James M. Laing same</span>	
18. <span style="font-size: 1.2em;">200.01</span>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<span style="font-size: 1.2em;">Reticulum Cell Sarcoma metastatic</span>		<span style="font-size: 1.2em;">5 months</span>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <span style="font-size: 1.2em;">none</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">March 27</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">March 29</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">March 29</span> 19 <span style="font-size: 1.2em;">70</span> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Manuel Levin M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">3/30/70</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MANUEL LEVIN M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">6101 Park Heights Ave, Balto Md 21215</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/1/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Parkwood</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 30 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Vickers</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Leonard J. Ruck Inc. Balto. Md.</span>	

1000 Main St  
New York City

1000 Main St  
New York City

Aug. 22, 1933

Dear Sirs:

Yours of July 27

has been received.

Very truly yours,  
John D. Rockefeller

Enc.

Enc.

Yours

Yours truly,  
John D. Rockefeller

Yours truly,  
John D. Rockefeller

Manuel L. Brown, no 1000 Main St, New York City  
X  
8/30/33

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3321</span>	
1-525 70 3321				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Johnson Ada</u>		2. DATE AND HOUR OF DEATH <u>3:30pm 3/23/70</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2562</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N.N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-1-05</u>		9. AGE (In years last birthday) <u>65</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Wright (Dec)</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES P (Dec)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-50-8582-B</u>		17. INFORMANT ADDRESS	
18. <u>45-0X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Respiratory and</u> DUE TO, OR AS A CONSEQUENCE OF: <u>min.</u>			
ANTECEDENT CAUSES		(B) <u>C. H. F.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>months</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>PULMONARY Embolism</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>21st March 1970</u> to <u>23 March 1970</u> that (I) (we) last saw the deceased alive on <u>3:30pm</u> 19 <u>23</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dhanbir S. Saluja</u> DEGREE				23B. DATE SIGNED <u>3/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>DHANBIR S. SALUJA</u> DEGREE				23D. ADDRESS <u>S. B. G Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/27/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Cemetery</u>	
24D. LOCATION (City, town, or county) <u>BALTO</u>		24E. STATE <u>MD.</u>		24F. COUNTY	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Chilington A. Phillips</u> ADDRESS <u>1727 W. Monroe St.</u>	

Bookeit Dr



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

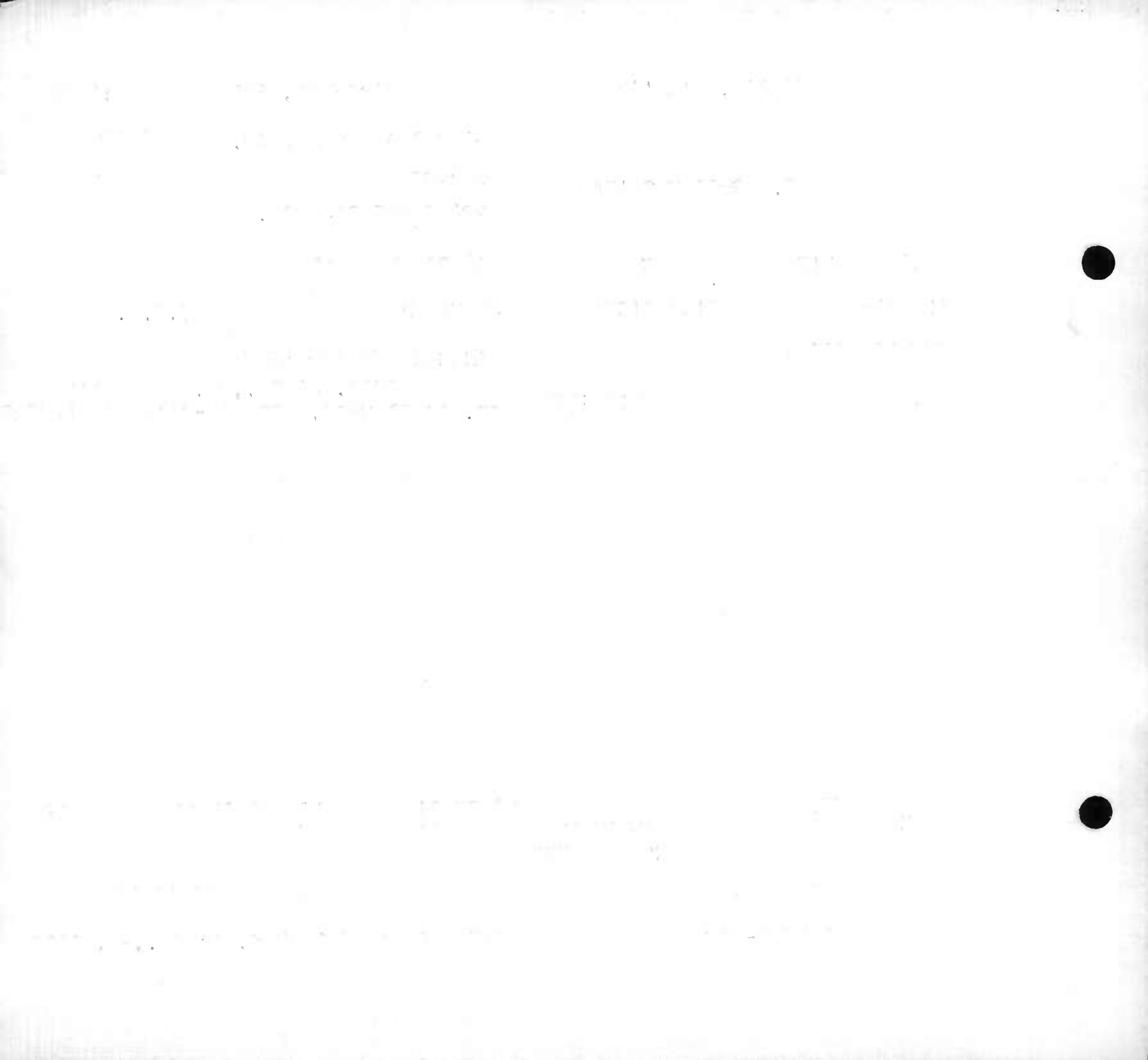
Baltimore City Health Department				X		REG. NO. 70 3322	
BIRTH NO. 11-000				70 3322		70 3322	
1. NAME OF DECEASED (Type or Print) <u>May, Thurston Scott</u>				2. DATE AND HOUR OF DEATH <u>3/25/70</u> <u>6:00 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4017 LIBERTY HOLTS AVE</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 GRANADA NURSING HOME</u>		A. STATE <u>Maryland Balto.</u>		B. COUNTY <u>5300</u>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		C. CITY OR TOWN <u>Phoenix</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-13-79</u>		9. AGE (in years last birthday) <u>90</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William May</u>				14. MOTHER'S MAIDEN NAME <u>Lucy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>228-20-1764 T</u>		17. INFORMANT <u>Lindsey Funeral Home, Harrisonburg, Va.</u>			
18. <u>412.41</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/19/</u> 19 <u>70</u> to <u>3/25/</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/25/</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Hollis Seunarine, M.D.</u>				23B. DATE SIGNED <u>3/25/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Hollis Seunarine, M.D.</u>	
23D. ADDRESS <u>1801 Greenberry Rd.</u>		23E. ADDRESS <u>1801 Greenberry Rd.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-28 1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Crawford Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Mt. Crawford, Va. 22841</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1970</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks</u>		25D. ADDRESS <u>Towson, Md. 21204</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-625</b>		BALTIMORE CITY HEALTH DEPARTMENT		70 3323	
1. NAME OF DECEASED (Type or Print) <b>MERSON, WILLIAM</b>			2. DATE AND HOUR OF DEATH <b>MARCH 22, 1970 9:45AM M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>40 ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD CO.</b> <b>20810 6300</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>			C. CITY OR TOWN <b>SAVAGE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>FIRE FIGHTER</b>		8. DATE OF BIRTH <b>06 25 87</b>
13. FATHER'S NAME <b>THOMAS MERSON</b>			14. MOTHER'S MAIDEN NAME <b>LITITIA (SHOEMAKER)</b>		9. AGE (In years last birthday) <b>82</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>213017739</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
17. INFORMANT <b>AVES. BALTO., MD.</b>			ADDRESS <b>21229 ST. AGNES HOSP. RECORDS-CATON &amp; WILKENS</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ch-Renal Failure</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>MARCH 21</b> 19 <b>70</b> to <b>MARCH 22</b> 19 <b>70</b> that <del>(X)</del> (we) last saw the deceased alive on <b>MARCH 22</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Zaheer-Kahn</b>				23B. DATE SIGNED <b>03 22 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZAHEER-KAHN</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/25/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Savage Cemetery</b>	
24D. LOCATION <b>Savage Md</b>		24E. NAME of REGISTRAR <b>Robert E. Taylor, M.D.</b>		24F. FUNERAL DIRECTOR <b>Donaldson Funeral Home</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Donaldson Funeral Home</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

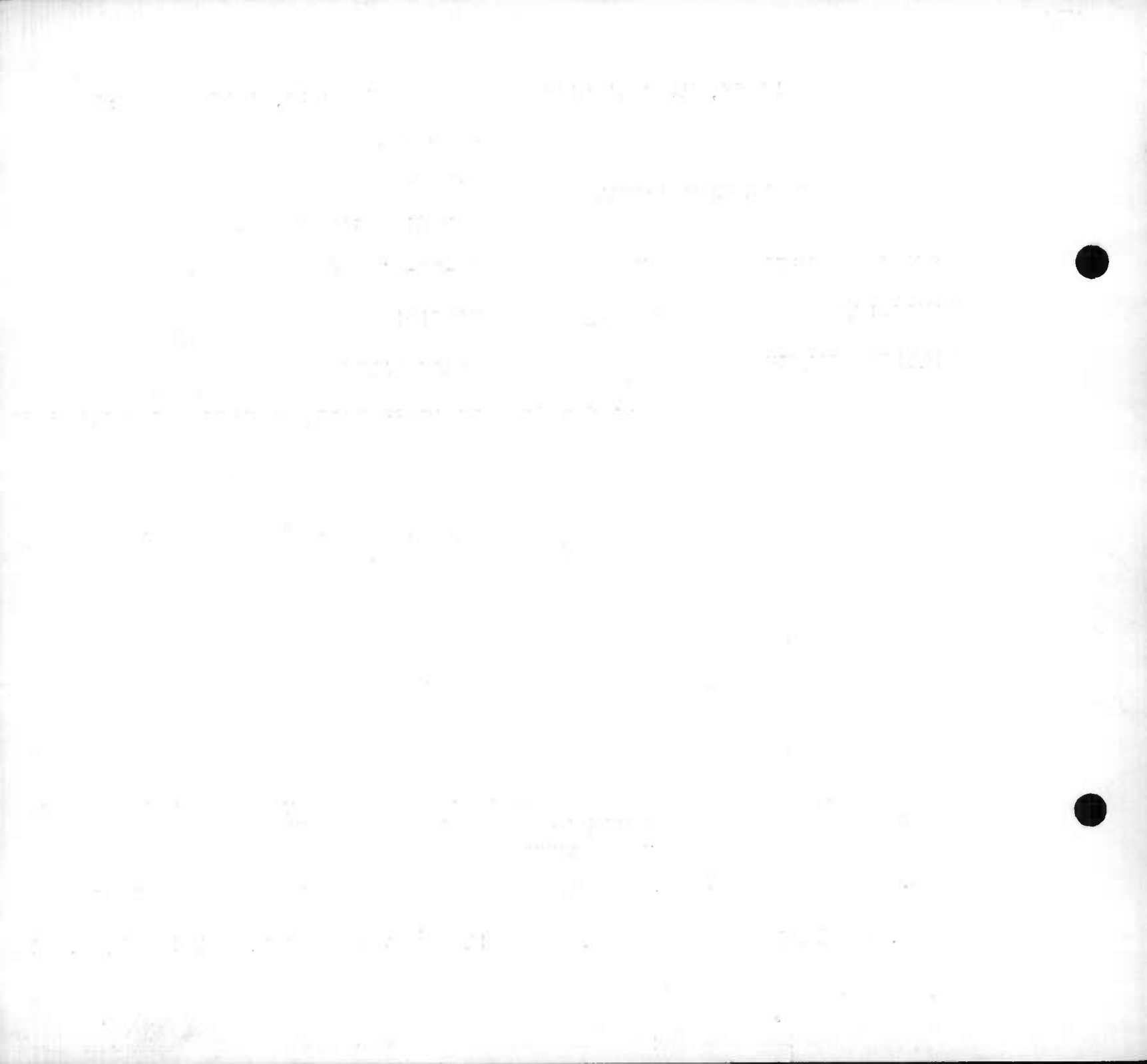
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 3324	
BIRTH NO. <u>7-200 70 3324</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Huston H. Rouse</u>				2. DATE AND HOUR OF DEATH <u>3/25/70</u> <u>8 am</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hosp</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>Prince George</u>	
				C. CITY OR TOWN <u>Laurel</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>Rt 2 Box 127 A</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-89</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Rouse</u>				14. MOTHER'S MAIDEN NAME <u>Lucindy Wolfe</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-46-8350</u>		17. INFORMANT <u>Bertha Rouse</u>		ADDRESS <u>S/A</u>	
18. <u>441.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ruptured Abdominal Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> 19 <u>70</u> to <u>3/25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Henry L. Nobel M.D.</u>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		DEGREE		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/28/70</u>		<u>Bateman Grove Cem</u>		<u>Rose Hill Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor, M.D.</u>		ADDRESS <u>Samuel, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MBJ 1		BALTIMORE CITY HEALTH DEPARTMENT		X	
K-524		70 3325		70 3325	
BIRTH NO.		70 3325		REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KNISLEY, MARY LILLIAN			MARCH 19, 1970 6:30P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN JESSUP D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BOX #128 GILFORD RD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-20-01	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME WILLIAM SEALOCK		
14. MOTHER'S MAIDEN NAME NANCY RILEY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		
16. SOCIAL SECURITY NO. 219286867			17. INFORMANT BALTO MD ST AGNES RECORDS WILKENS & CATON AVES		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema one day			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sever Coronary artery disease years			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from MARCH 19 19 70 to MARCH 19 19 70 that (2) (we) last saw the deceased alive on MARCH 19 19 70 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE Bighan, Ebrahim MD			23B. DATE SIGNED 03-20-70		
23C. PHYSICIAN'S NAME (Type) DR. EBRAHIMY MD			23D. ADDRESS WILKENS & CATON AVE. BALTIMORE, MD. 2122		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/23/70		24C. NAME of CEMETERY or CREMATORY Savage Cemetery Maryland	
24D. LOCATION (City, town, or county) (State) Savage Maryland		24E. DATE RECD BY HEALTH DEPT. MAR 30 1970		24F. NAME OF REGISTRAR E. E. E. E.	
24G. FUNERAL DIRECTOR D. H. E. E.		24H. ADDRESS D. H. E. E.			





F-624		70 3326		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		70 3326	
BIRTH NO.		REG. NO.							
1. NAME OF DECEASED (Type or Print) DAVID FRIZZELL Sr/		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year		3. DATE PRONOUNCED DEAD Month Day Year 3 22 70		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2634	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6-20-28		10. AGE (In years lost birthday) 41		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 1001 Hignet Way	
13. FATHER'S NAME B. W. Frizzell		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth. Steel Co.		14B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		15. MOTHER'S MAIDEN NAME Fronnie Clark		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army	
17. SOCIAL SECURITY NO. 214-32-2055		18. INFORMANT Brother 5322 Wrightsville Avenue Paul Frizzell Greenville, N. C. 28401		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E814.1 Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5600 blk. Pulaski Hwy. 97' w. of Erdman Ave. cutoff		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 3-27-70		24C. NAME OF CEMETERY or CREMATORY Reedy Branch Cemetery		24D. LOCATION (City, town, or county) (State) Greenville, Pitt Co. N.C.	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md. 21222		DATE SIGNED 3-23-70	

1

1. Name of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Name and Address of Physician

6. Name and Address of Coroner

7. Name and Address of Medical Examiner

8. Name and Address of Hospital

9. Name and Address of Funeral Home

10. Name and Address of Undertaker

11. Name and Address of Burial Place

12. Name and Address of Cemetery

13. Name and Address of Interment

14. Name and Address of Burial

15. Name and Address of Burial

16. Name and Address of Burial

17. Name and Address of Burial

18. Name and Address of Burial

19. Name and Address of Burial

20. Name and Address of Burial

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.	
C-652 70 3327		70 3327			
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>MR. THEODORE E. CROUNSE</b>			2. DATE AND HOUR OF DEATH <b>3/23/70 11:39 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home &amp; Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL</b> <b>BALTIMORE, MARYLAND 21231</b>			C. CITY OR TOWN <b>Sparrows Point</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>BALTIMORE</b>		
E. STREET AND NUMBER <b>Rt. 10 Box 500</b> <b>North Pt., Blvd., Baltimore, Md.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/6/07</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Consolidated Engineering</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>ELI CROUNSE</b>			14. MOTHER'S MAIDEN NAME <b>AGNES ALLISON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-7411</b>		17. INFORMANT (Daughter) <b>CHRISTINE HOOK</b> ADDRESS <b>1726 ALLENHAM RD. Dundalk, Md. 21222</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASHD, atrial fibrillation</b>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASHD, atrial fibrillation</b>					
(C) <b>Chr. Congestive heart failure, Pulmonary embolism</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/23/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/20 1970</b> to <b>3/23 1970</b> that (I) (we) last saw the deceased alive on <b>3/23 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. E. Chouvalit</b>			23B. DATE SIGNED <b>3/23/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>A. E. CHOUVALIT, M.D.</b>			23D. ADDRESS <b>Church Home &amp; Hospital, Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Eldersburg, Carroll Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3328

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARETT E. STOKES

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

March 25, 1970

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

00

2017 E. Monument Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 25, 1970

11:35 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. COUNTY

604

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 16, 1882

10. AGE (In years  
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2017 E. Monument Street

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Cornelius Toomey

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

at home

15. MOTHER'S MAIDEN NAME

Catherine Hunt

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Ellen Gehlfuss, sister, above

19.

4124

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 26, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/30/70

24C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.

3331 Brehms Lane

MAR 30 1970

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5-365 70 3329 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3329

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
WILLIAM J. STROMBERG		March 25, 1970					M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
00 1703 Aliceann Street		March 25, 1970					8:30 P.M.
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN	
Male		White				Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
JUNE 3, 1912		58		MD.		USA.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
SEAMAN		MERCHANT MARINE		ELIZABETH CARR		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. CAUSE OF DEATH	
		Mrs Anna Murphy - 409 Old Frederick Rd				Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.4				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? (Yes or No)	
		0				No	
29. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		31. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		32. HOW DID INJURY OCCUR?	
29. TIME (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED		31. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
29. (APPROX.)							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 26, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-28-70		Cathedral Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
MAR 30 1970		Robert E. Taylor		Judy-Cronough		Catonsville, Md.	

VS 151-REV. 1/1/68

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WALLACE BROWN

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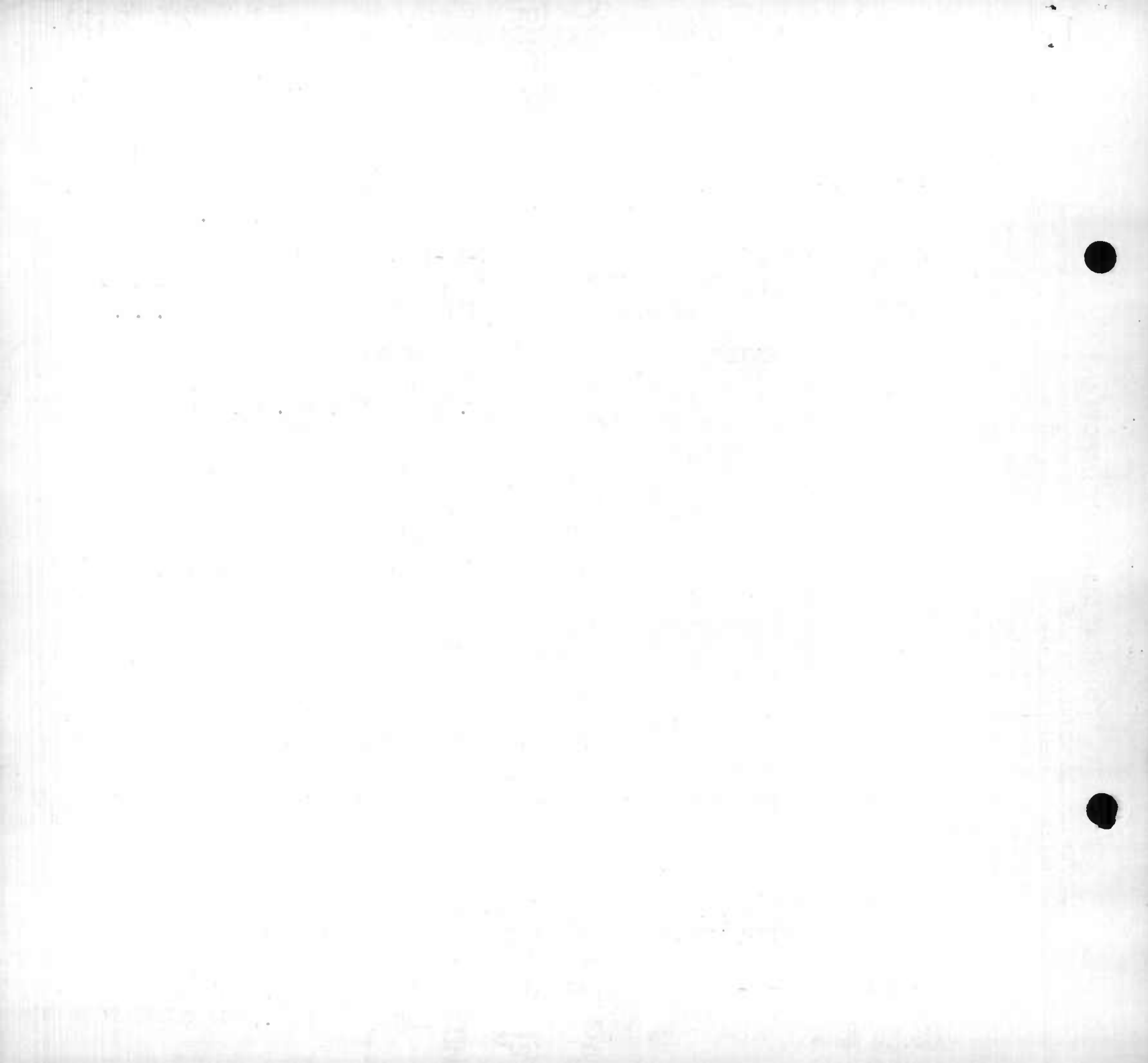
1951



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

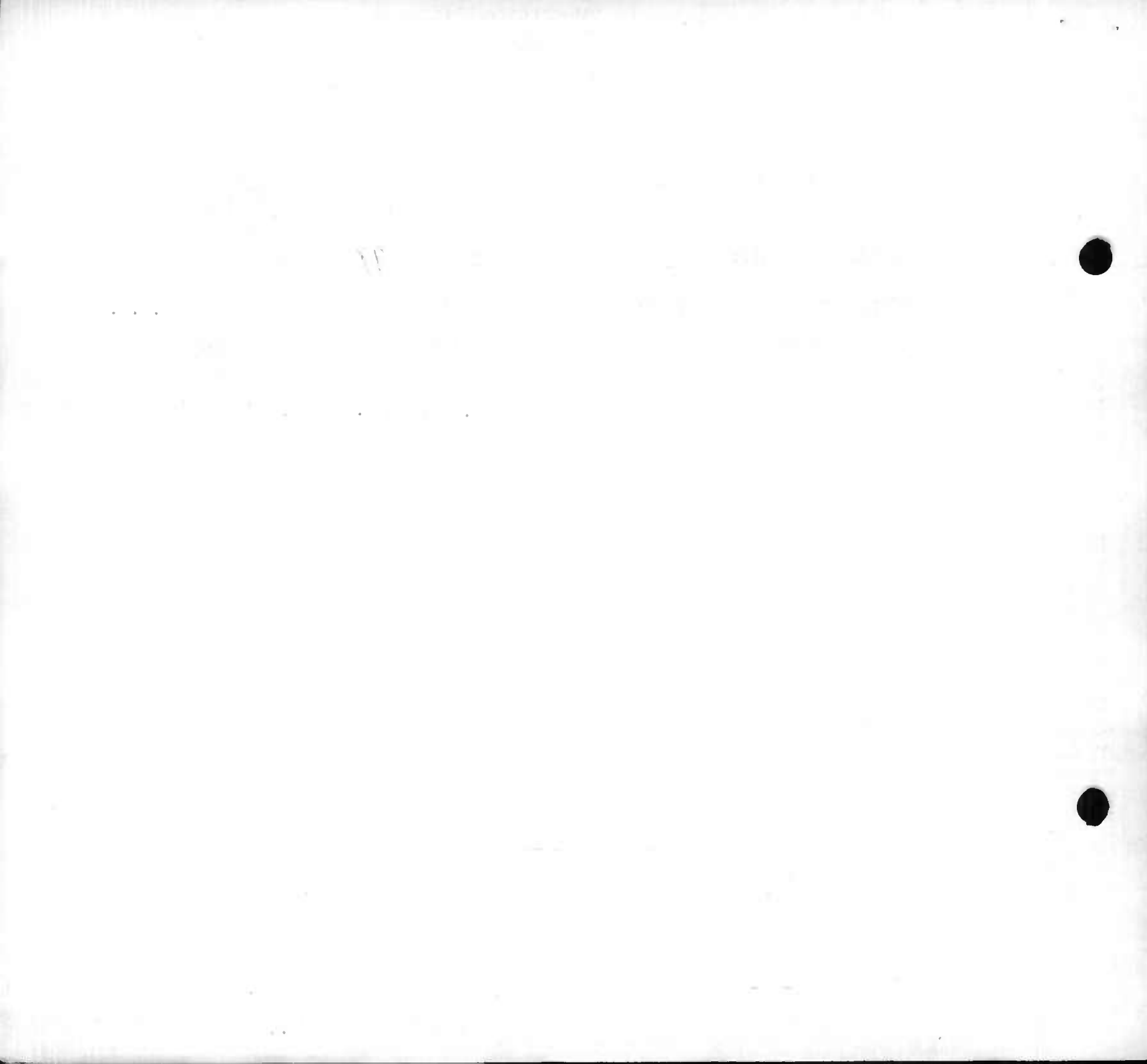
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3330</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">B-450 70 3330</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
IDA BLOOM		MARCH 24, 1970		10:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
JEWISH CONVELESANT HOME		MARYLAND		2730	
90		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3003 ROMARIC COURT, APT. F 1			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-20-1895	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		LITHUANIA	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
UNKNOWN BECKER		UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MR. LEON BLOOM, APT. F1, 3003 ROMARIC COURT	
18. 43371		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebral Thrombosis			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Atherosclerosis			
II		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 20 1970 to March 24 1970, that (I) (we) last saw the deceased alive on March 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Nathan C. Needle		3/25/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NATHAN NEEDLE		6506 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		3-26-70		WORKMEN CIRCLE	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
BALTIMORE, MARYLAND		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 30 1970		Robert E. Needle			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3331</u>	
K-450		70 3331		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SARAH KLEIN</u>		2. DATE AND HOUR OF DEATH <u>3-25-70</u> <u>2:37 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2717</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1/2 SINAI HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2500 Belvedere Ave.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-99</u>	9. AGE (In years last birthday) <u>71</u>	10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>AARON KRAVETZ</u>		14. MOTHER'S MAIDEN NAME <u>LEAH DANISHEFSKY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. HERMAN E. KLEIN, 6004 IVYDENE TERRACE #7</u>	
18. <u>4/10/9</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<u>ACUTE PULMONARY EDEMA</u>		<u>1 hr.</u>	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<u>ACUTE MYOCARDIAL INFARCTION</u>		<u>36 h.</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>A. S. C. V. D.</u>		<u>YEARS</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>March 24 1970</u> to <u>March 25 1970</u> that (1) (we) last saw the deceased alive on <u>March 25 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alberto Angulo</u>		23B. DATE SIGNED <u>3-25-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALBERTO ANGULO, M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

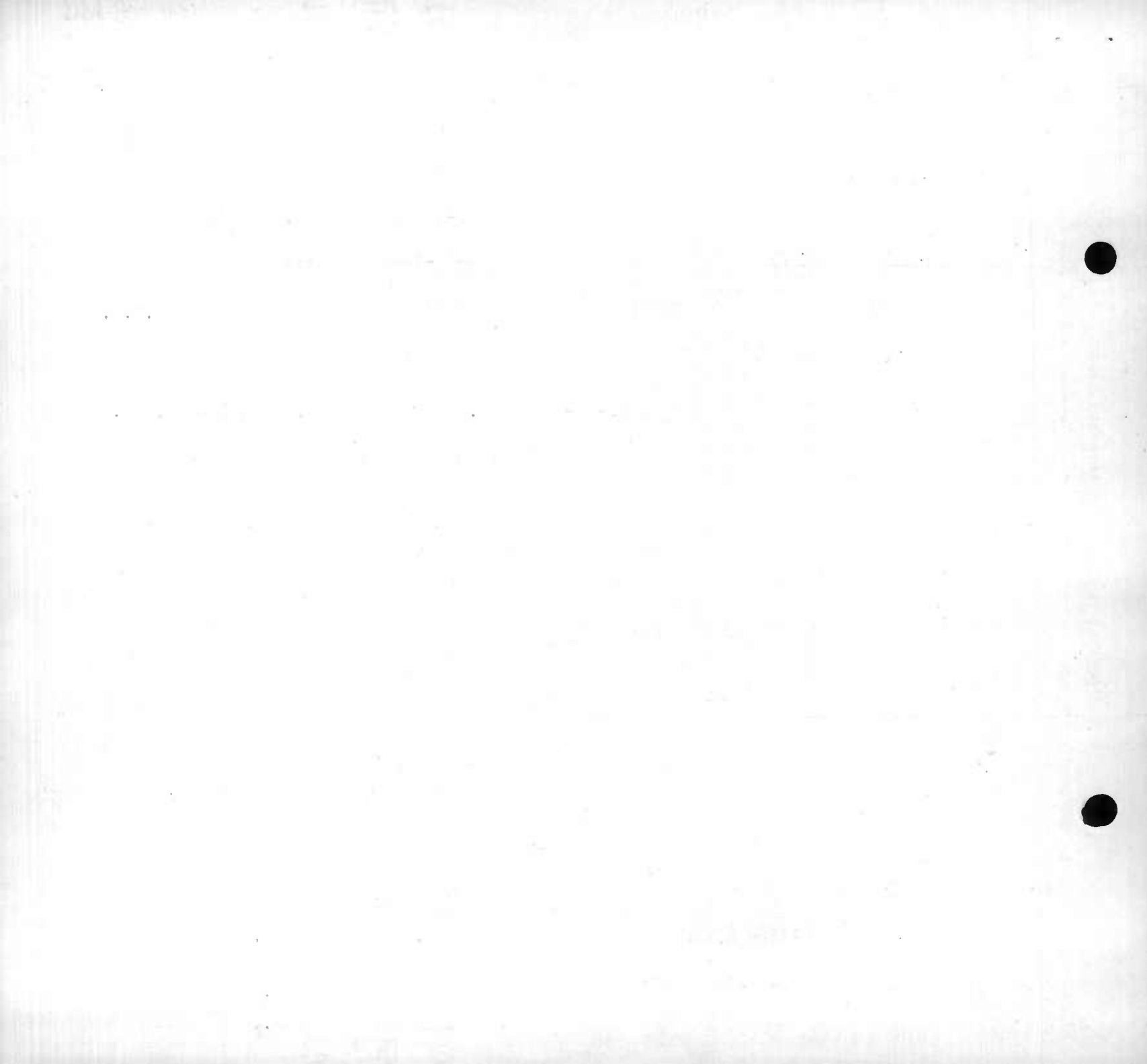
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3332</b>	
P-452 <b>70 3332</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Morris Polansky</b>		2. DATE AND HOUR OF DEATH <b>3/26/70 9:12 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Church Home and Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto. City</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home and Hospital</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/7</b> 9. AGE (in years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Copper AGE</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Making Bands</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russian US.A.</b>	
13. FATHER'S NAME <b>Erin Morris Polansky</b>		14. MOTHER'S MAIDEN NAME <b>Eva ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-07-6954</b>	
		17. INFORMANT <b>Mrs. Minnie Polansky (wife)</b> ADDRESS <b>7 N. LUZERNE AVE.</b>	
18. <b>157.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Extensive metastatic CA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Stomach</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mo</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> 19 <b>69</b> to <b>3/26</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Feb</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>J. M. Zimmerman MD</b>		23B. DATE SIGNED <b>3/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. M. ZIMMERMAN MD</b>		23D. ADDRESS <b>100 N. Broadway</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-27-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>WORKMENS CIRCLE</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>		25B. NAME OF REGISTRAR <b>J. M. Zimmerman</b>	
		25C. FUNERAL DIRECTOR <b>Ed. Terrian</b> ADDRESS <b>6010 Reisterstown Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3333</span>	
B-412 70 3333				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ABRAHAM BLIVESS</b>			2. DATE AND HOUR OF DEATH <b>MARCH 24, 1970</b> <span style="float: right;">6 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2720</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>3700 GLEN AVENUE</b> <b>00</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>3700 GLEN AVENUE, 2nd FLOOR</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1892</b>	9. AGE (In years lost birthday) <b>77</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>JEWELER</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MAX BLIVESS</b>			14. MOTHER'S MAIDEN NAME <b>ADELE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-32-6909</b>	17. INFORMANT <b>MR. MORRIS BLIVESS, RANDALLSTOWN, MD. 21133</b>		
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Ante-mortem heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <b>Ante-mortem heart disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b>
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>3/24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/24</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Milton Kirsh</b>			23B. DATE SIGNED <b>3/25/70</b>		23C. PHYSICIAN'S NAME (Type) <b>MILTON KIRSH</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>			25B. NAME OF REGISTRAR <b>Paul E. Fisher</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			24E. ADDRESS <b>4000 W. NORTHERN PKWY.</b>		





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
7-635 70 3334		CERTIFICATE OF DEATH		70 3334	
1. NAME OF DECEASED (Type or Print) <b>NORBERT FRIEDMAN</b>			2. DATE AND HOUR OF DEATH <b>MARCH 24, 1970 12<sup>30</sup> P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>XX 3408 WABASH AVENUE</b> <b>00</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15 11</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3408 WABASH AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-1892</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>	
13. FATHER'S NAME <b>JACOB FRIEDMAN</b>			14. MOTHER'S MAIDEN NAME <b>BRINDELL ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-22-3097</b>		17. INFORMANT ADDRESS <b>MRS. BERNICE ABRAMS, 7605 LORRY LANE #21208</b>	
18. I <b>1621 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinoma of lung metastatic</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>none</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b> <b>2 years</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>Dec 1</b> 19 <b>68</b> to <b>March 24</b> 19 <b>70</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 24</b> 19 <b>70</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Manuel Levin M.D.</b>			23B. DATE SIGNED <b>3/24/70</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN M.D.</b>			23D. ADDRESS <b>6101 Park Hgts. Ave, Balto Md 21215</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-26-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

Carroll County  
West Virginia

1890  
1891  
1892

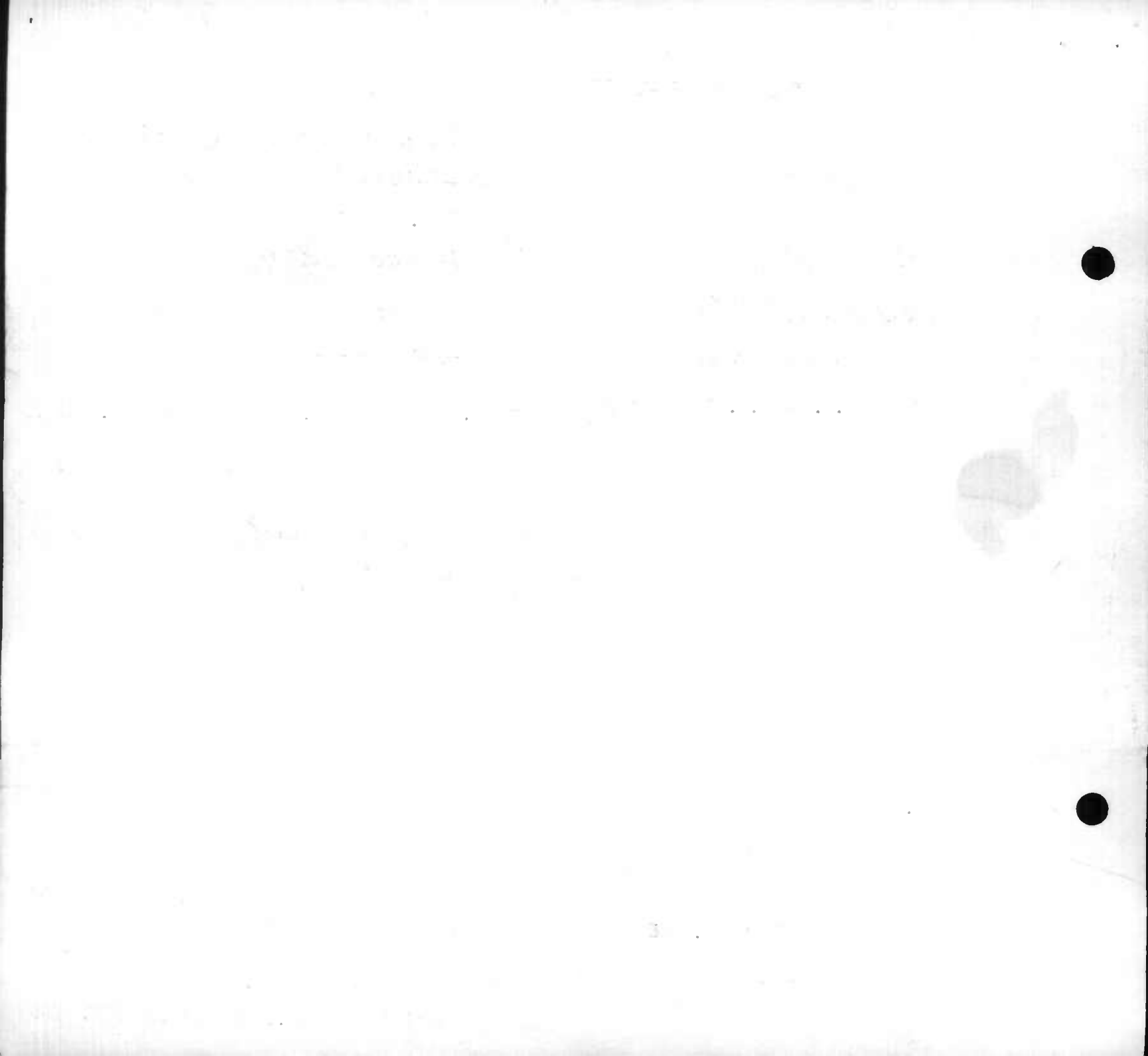
1893

1894

James Lewis  
1895

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3335			
P-621 70 3335				REG. NO. 70 3335			
BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>ISRAEL PEREGOFF</b>				2. DATE AND HOUR OF DEATH <b>3-23-70 5:40 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b>		B. COUNTY	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1338 S. HANOVER STREET</b>		<b>2301</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>XXX XXX XXX</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician EMPLOYEE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>GENERAL ELECTRIC</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>JOSEPH PEREGOFF</b>			14. MOTHER'S MAIDEN NAME <b>BESSIE ITSKOFF</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.I &amp; W.W.II ARMY</b>			16. SOCIAL SECURITY NO. <b>21903/6569/A</b>		17. INFORMANT <b>MRS. JOSEPH NEWMAN, 3341 AVONDALE AVE. #21215</b>		
18. <b>600X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE <b>Uremia, Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>18 days</b>	
				(B) <b>Chronic Pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>several years</b>	
				(C) <b>Benign Prostatic Hypertrophy</b>		<b>" "</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>3-5-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-5-70</b> to <b>3-23-70</b> that (I) (we) last saw the deceased alive on <b>3-23-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard H. Reed M.D.</b>				23B. DATE SIGNED <b>3-24-70</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD H. REED REED</b>	
23D. ADDRESS <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-26-70</b>	
24C. NAME of CEMETERY or CREMATORY <b>OHR KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND</b>				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 30 1970</b>				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 70 3336		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3336	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Alice Pauline Parks		3-27-70 2:15 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 50. Balto. Gen. Hosp.		A. STATE Maryland		B. COUNTY Anne Arundel	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Bk. Heights		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 5214 Brookwood Road		21225	
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1912	9. AGE (In years last birthday) 57	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10B. KIND OF BUSINESS OR INDUSTRY Self-emp.		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Margaret Foster	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-9417		17. INFORMANT James Parks	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MI ASCVD - Coronary disease 12 hrs 3 years		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 19 57 to March 19 70, that (I) (we) last saw the deceased alive on 2-2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ewald H. Weiss, M.D.		23B. DATE SIGNED 3-27-70			
23C. PHYSICIAN'S NAME (Type) Ewald H. Weiss, M.D.		23D. ADDRESS 615 Hammonds Lane		Baltimore, Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-30-70		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.	
24D. LOCATION Glen Burnie, (AA) Md.		24E. DATE RECEIVED BY HEALTH DEPT. MAR 31 1970		24F. NAME OF REGISTRAR 2300 E. Johns Rd.	
24G. DATE RECEIVED BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR McCully - 237 Patapsco Ave	
24J. ADDRESS BALTO. 21225		24K. ADDRESS		24L. ADDRESS	



C-636

70 3337

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3337

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES E. CARTER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 24 70 9:12 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 24, 1970 9:12 p M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Oct. 18, 1926</b>		10. AGE (In years lost birthday) <b>43</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clinton A. Carter</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pump Operator</b>	
15. MOTHER'S MAIDEN NAME <b>Bessie M. Bloomfield</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 11</b>	
17. SOCIAL SECURITY NO. <b>212 20 9163</b>		18. INFORMANT ADDRESS <b>Mrs. Catherine A. Carter (wife) Same As #5</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Tsodore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 28/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>J. E. Vandyke, M.D.</b>	
25C. FUNERAL DIRECTOR <b>R.V. Singleton</b>		ADDRESS <b>Singleton Funeral Home Glen Burnie, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-600		70 3338		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3338	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BING YOUNG DER / DEA</u>				2. DATE AND HOUR OF DEATH <u>MARCH 28, 1970</u> <u>2:30AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>9-04</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3000 FRISBY STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>YELLOW</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-05</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>		11. BIRTHPLACE (State or foreign country) <u>CHINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT : <u>Son</u>		ADDRESS <u>1710 ROLAND AVE., BALTO., MD 21204</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CHRONIC LUNG DISEASE</u> <u>BLEEDING GASTRIC ULCER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 27</u> 19 <u>70</u> to <u>MARCH 28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MARCH 28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>3/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>YU. SUI LIT</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>STEWART &amp; MOWEN CO. 108 W. North Av. City 1</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

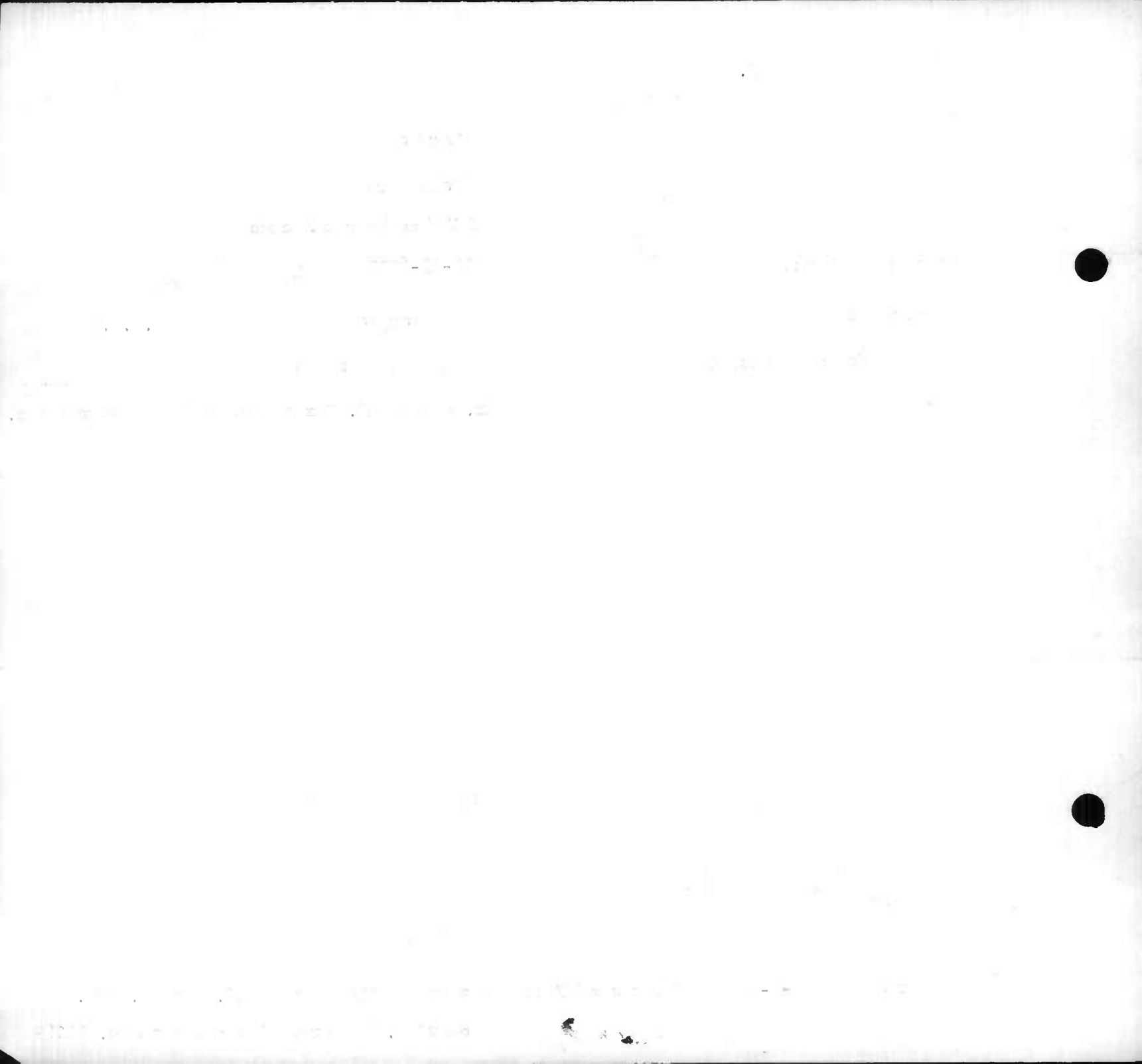
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3339</span>	
CERTIFICATE OF DEATH					
S-140 70 3339					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MCDONALD R. SHIPLEY</u>		2. DATE AND HOUR OF DEATH <u>3/28/70 230 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-98</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp. Balto</u>		C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3901 W. Garrison Ave</u>			
5. SEX <u>AF</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/25</u>	9. AGE (in years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Landrum</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Stinnette</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-7476</u>		17. INFORMANT <u>Mr. Albert F. Shipley, 3901 W. Garrison Ave.</u>	
18. <u>320.91</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute P.L. occlusion</u>		<u>6 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>P.L. emboli</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>Arteriosclerosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Acute Nephritis</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3/28/70</u> to <u>3/28/70</u> and that (1) (we) last saw the deceased alive on <u>3/28/70</u> and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. M. V. [Signature]</u>		23B. DATE SIGNED <u>3/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23D. ADDRESS <u>[Signature]</u>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-1-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION <u>Washington Blvd., Howard Co., Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>			
24F. NAME OF REGISTRAR <u>R. E. [Signature]</u>		24G. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		24H. ADDRESS <u>4107 Wilkens Ave. 21229</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

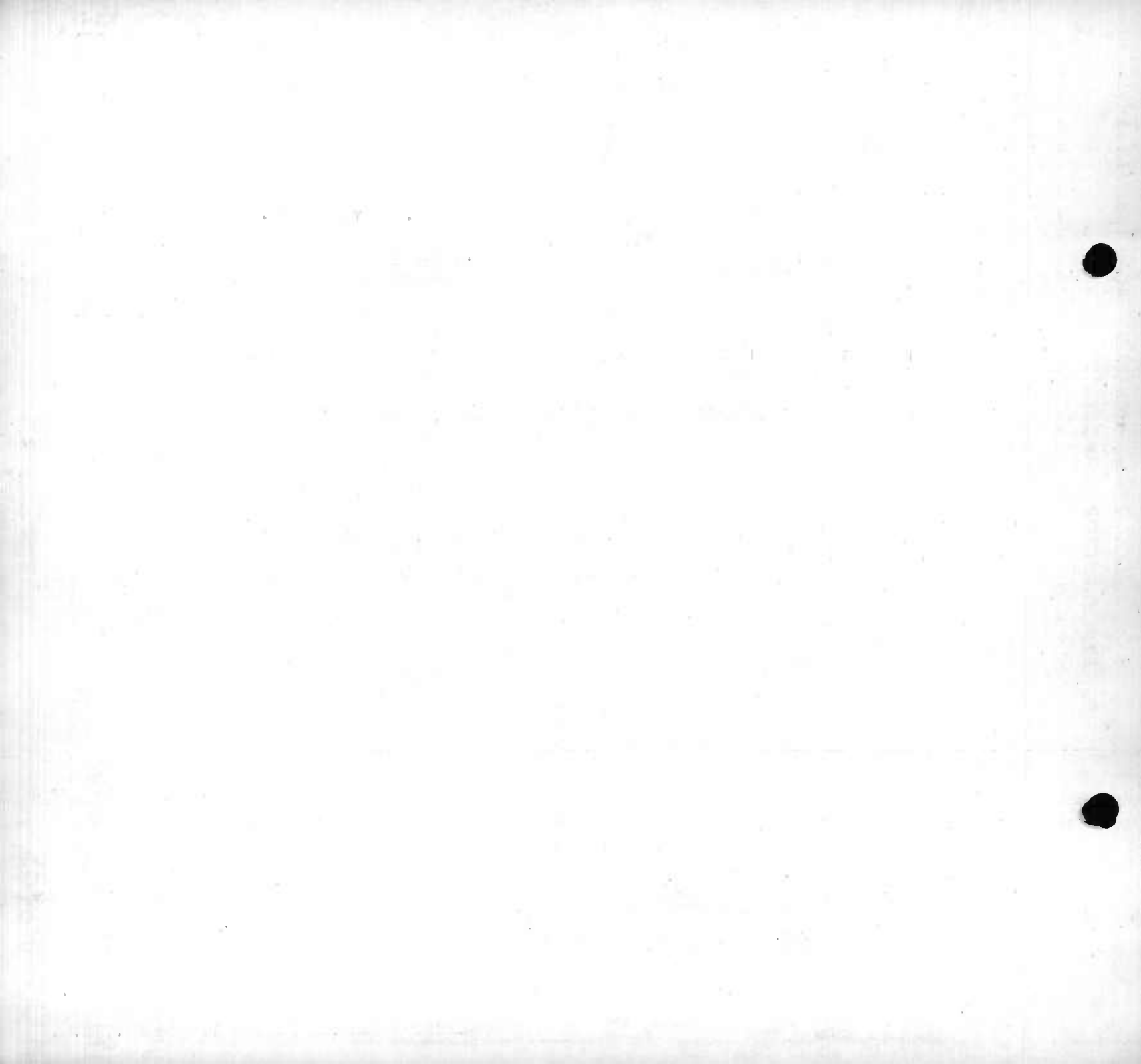
V-632 70 3340				BALTIMORE CITY HEALTH DEPARTMENT		70 3340	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Eleanor Verdechian</i>				2. DATE AND HOUR OF DEATH <i>3-30-70</i>   <i>3:15</i> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i>		B. COUNTY <i>27-48</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1312 Woodbourne Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-1917</i>	9. AGE (in years last birthday) <i>52</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Felix Zaleski</i>			14. MOTHER'S MAIDEN NAME <i>Mollie Smalowski</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>21212 Mr. Anthony J. Verdechian, 1312 Woodbourne Ave.</i>		
18. <i>734.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Possible Congestive Heart Failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Uremia pneumonia</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Scleroderma &amp; renal failure</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Hypertension 2° to above</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Mar. 14 1970</i> to <i>Mar. 30 1970</i> that (I) (we) last saw the deceased alive on <i>Mar. 20 1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. T. Hipocito, M.D.</i>				23B. DATE SIGNED <i>3/30/70</i>		23C. PHYSICIAN'S NAME (Typed) <i>A. T. Hipocito, M.D.</i>	
23D. ADDRESS <i>MERCY HOSPITAL</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-2-1970</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Trumps Mill Rd., Balto., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 21 1970</i>		25B. NAME OF REGISTRAR <i>R. E. S. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-632 70 3341		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 70 3341	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
ALIX HOROWITZ				2. DATE AND HOUR OF DEATH March 25, 1970 1 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND MONTGOMERY 65-00			
THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN SILVER SPRING		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 75 E. WAYNE AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-02	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Merchant		Grocery		Russia		U. S. A.	
13. FATHER'S NAME GILBERT HOROWITZ				14. MOTHER'S MAIDEN NAME IDA ???			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-46-9543		17. INFORMANT Esther Horowitz, Same as 4		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HYPOTENSION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CARDIAC CATHETERIZATION (C) CORONARY ARTERY DISEASE yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Pending NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 20 1970 to March 25 1970, that (I) (we) last saw the deceased alive on March 25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James E. Muller				23B. DATE SIGNED March 25, 1970		23C. PHYSICIAN'S NAME (Type) JAMES E. MULLER MD	
23D. ADDRESS 1531 E. MONUMENT ST BALT, MD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-27-1970		24C. NAME OF CEMETERY or CREMATORY Ohev Sholom Cemetery		24D. LOCATION (City, town, or county) (State) Washington D. C	
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR J. E. Muller		25C. FUNERAL DIRECTOR ADDRESS Goldberg Funeral Home 4217 9th St., N.W.			

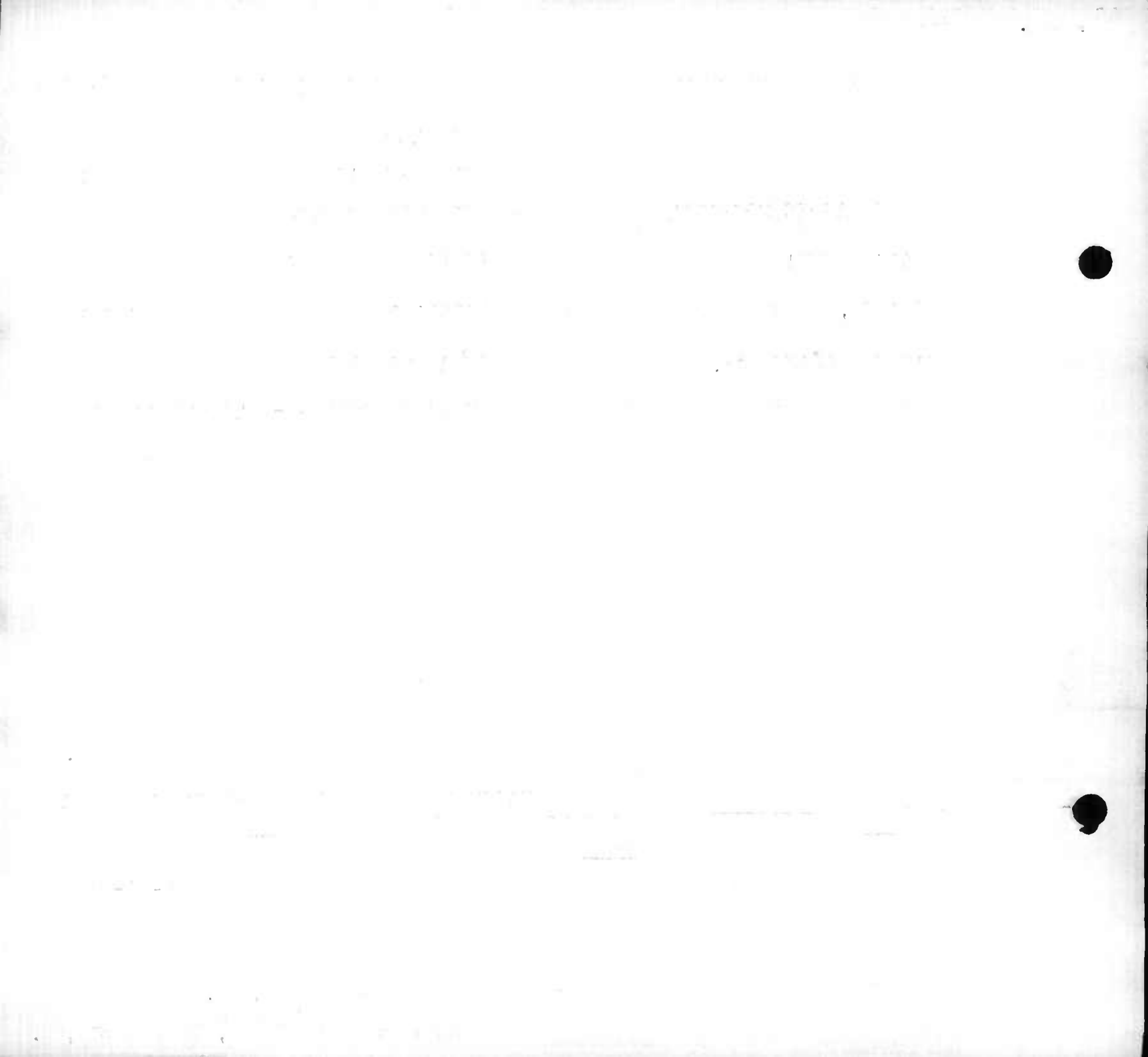




# FUNERAL DIRECTOR: IMPORTANT

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A-352		70 3342		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3342	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ADAMS, HARRY W				2. DATE AND HOUR OF DEATH MARCH 23. 1970		6:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY A. A. C. 52-00		C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 524 WIMMER ROAD					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 09 08	9. AGE (in years lost birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED, Chauffer	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U S A		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY B&A Railroad		13. FATHER'S NAME HARRY W ADAMS Sr.		14. MOTHER'S MAIDEN NAME EMMA SHEPPARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 216/16/8575		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 436.9 I CEREBRO-VASCULAR ACCIDENT		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: POSS. ARTERIOSCLEROTIC DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). BRONCHOPNEUMONIA ACUTE PYELONEPHRITIS				SEVERAL DAYS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES.			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MARCH 22 19 70 to MARCH 23 19 70 that (I) (we) last saw the deceased alive on MARCH 23 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Julio Freinaves M.D.				23B. DATE SIGNED 03-24-70		23C. PHYSICIAN'S NAME (Type) JULIO FREINAVES M.D.			
23D. ADDRESS ST. AGNES HOSPITAL/CATON AVE.		23E. ATTENDING PHYSICIAN Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION Baltimore, Md.		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR Robert E. Gaber, M.D.		25C. FUNERAL DIRECTOR N. Robinson		ADDRESS Singleton Funeral Home, Glen Burnie, Md.			



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D-550 70 3343		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3343	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCIS DINAN</b>		2. DATE AND HOUR OF DEATH <b>28 MARCH 1970 2:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-04</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>EDGEWATER NURSING HOME</b> <b>90 6000 BELLONA AVENUE BALTIMORE</b>		E. STREET AND NUMBER <b>734 EXETER HALL AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 3 1909</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>(FOREIGN) FREIGHT FORWARDING</b>		11. BIRTHPLACE (State or foreign country) <b>Jersey City, N.J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John T. DINAN</b>		14. MOTHER'S MAIDEN NAME <b>SARA DEALY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>063-05-5042</b>		17. INFORMANT <b>John A. DINAN</b> ADDRESS <b>7281 - 113rd St. FOREST HILL N.Y.</b>	
18. I, <b>John A. DINAN</b> , CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMATOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ADENOCARCINOMA CAECUM</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>2 YRS + 4 MONTHS</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>26 FEB 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11 MARCH 1970</b> to <b>25 MARCH 1970</b> that (I) (we) last saw the deceased alive on <b>28 MARCH 1970</b> and that (in my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>John B MacGibbon</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>28 MAR 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN B MAC GIBBON</b>		23D. ADDRESS <b>800 CATHEDRAL STREET</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Name Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Jersey City N.J.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jakes, M.D.</b>		25C. FUNERAL DIRECTOR <b>AB Wilson</b> ADDRESS <b>Singleton Funeral Home, Carey Avenue, Md.</b>	

John T. Dineen  
2nd Party

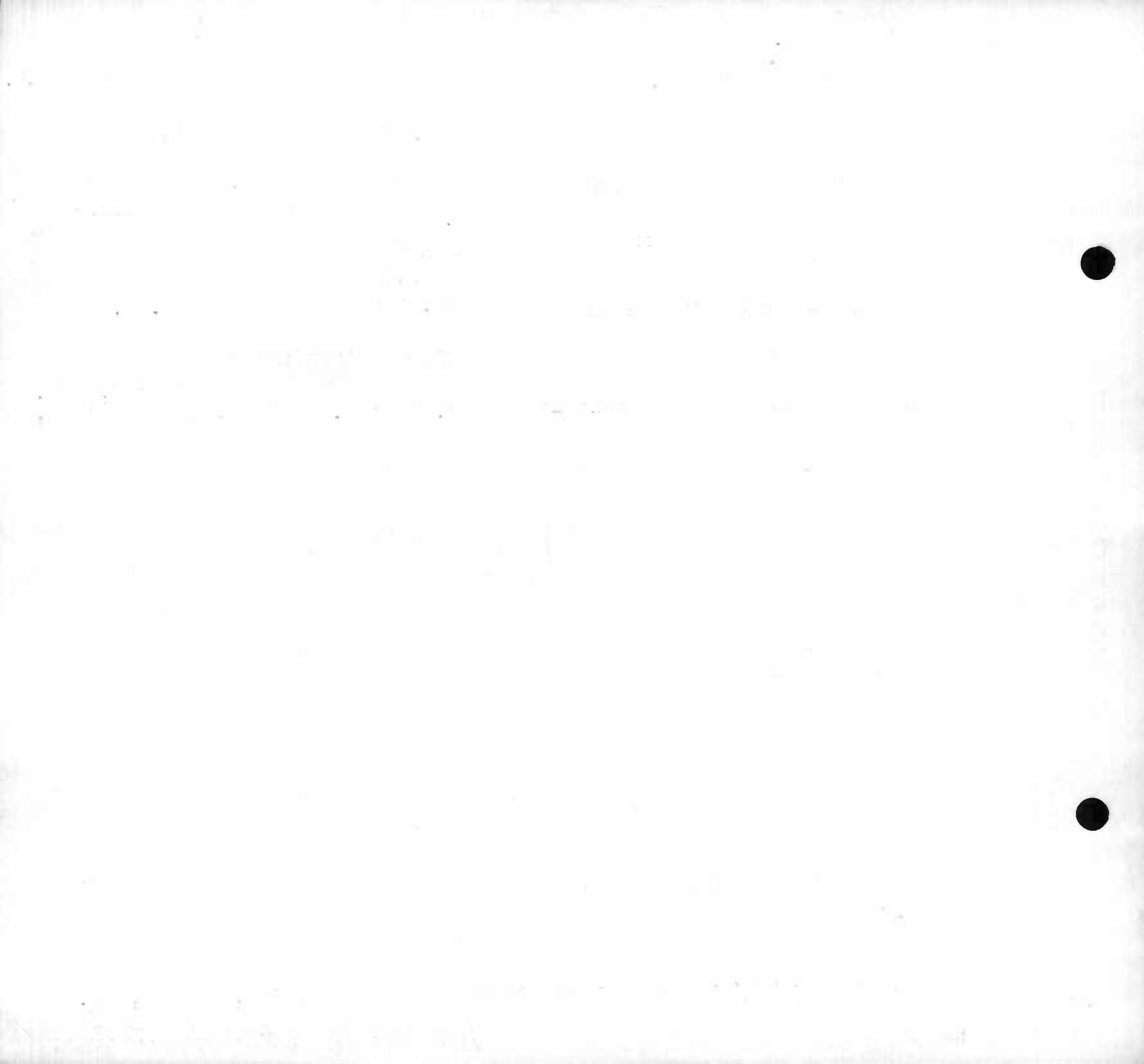
1981-11-27  
1981-11-27  
John A. Dineen

W.H. II

James White Head Name (Gated) Jersey City N.J.  
1981-11-27  
1981-11-27

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VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

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D-400 70 3345		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3345	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MALISSIE V. DALE		3-27-70 8:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland 21-02	
43 South Baltimore General Hospital				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1120 Carroll St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
F	W		May 4, 1896	73 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker at home				North Carolina	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George S. Vernon			Elizabeth Beelhard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Wilma Link-Lemire 201 Osbourne Ave 21228	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-26 1970 to 3-27 1970 that (I) (we) last saw the deceased alive on 3-27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Virginia Y. Fausto, M.D. DEGREE				3-27-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
VIRGINIA Y. FAUSTO, M.D. DEGREE				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/31/70		Cedar Hill Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 31 1970		R. E. Fausto, M.D.		John L. Conner, Son	
				ADDRESS 901	
				23rd St.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

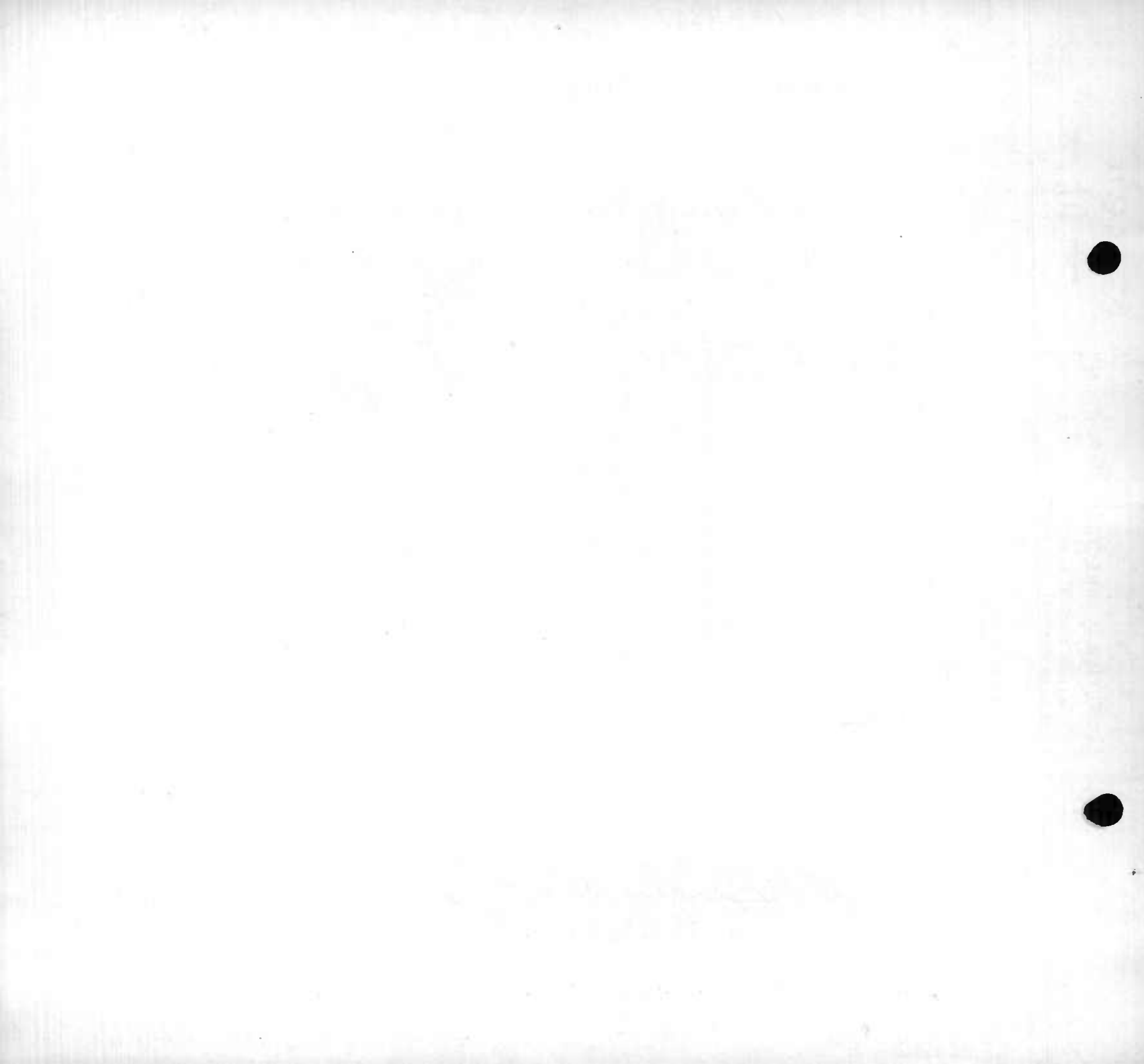
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">70 3346</span>	
F-230 <span style="font-size: 2em;">70 3346</span>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MRS. BARBARA FOCHT</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MARCH 28TH 12:30 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		5. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">CHURCH HOME + HOSPITAL</span> <span style="font-size: 1.2em;">35 100 N. BROADWAY</span> <span style="font-size: 1.2em;">BALTO., MD. 21231</span>		E. STREET AND NUMBER <span style="font-size: 1.2em;">318 S. WOODWARD DR.</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4/21/17</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">52</span>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Dept. Store</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">NEW YORK</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">EARL EDWARDS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">NANCY COMPTON</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">190 18 0557</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">CARL FOCHT 318 S. WOODWARD DR.</span>	
18. <span style="font-size: 1.2em;">720.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">LUMBAR SPINAL ABSCESS</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">LUMBAR SPINAL ABSCESS</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4 days</span>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">MARCH 19TH 1970</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">LUMBAR SPINAL ABSCESS</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <span style="font-size: 1.2em;">NO</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MARCH 12TH 1970</span> to <span style="font-size: 1.2em;">MARCH 28TH 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MARCH 28TH 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Ahmad Farouk Azam</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">MARCH 28TH 1970</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">AHMAD FAROUK AZAM MBBS</span>	
23D. ADDRESS <span style="font-size: 1.2em;">BALTO., MD 21231</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			
24B. DATE <span style="font-size: 1.2em;">3/31/70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Green Lawn Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Williamsport, Pa.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 31 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">John E. Zeb...</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Bruzdzinski Funeral Home</span>	
				ADDRESS <span style="font-size: 1.2em;">1407 Eastern Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

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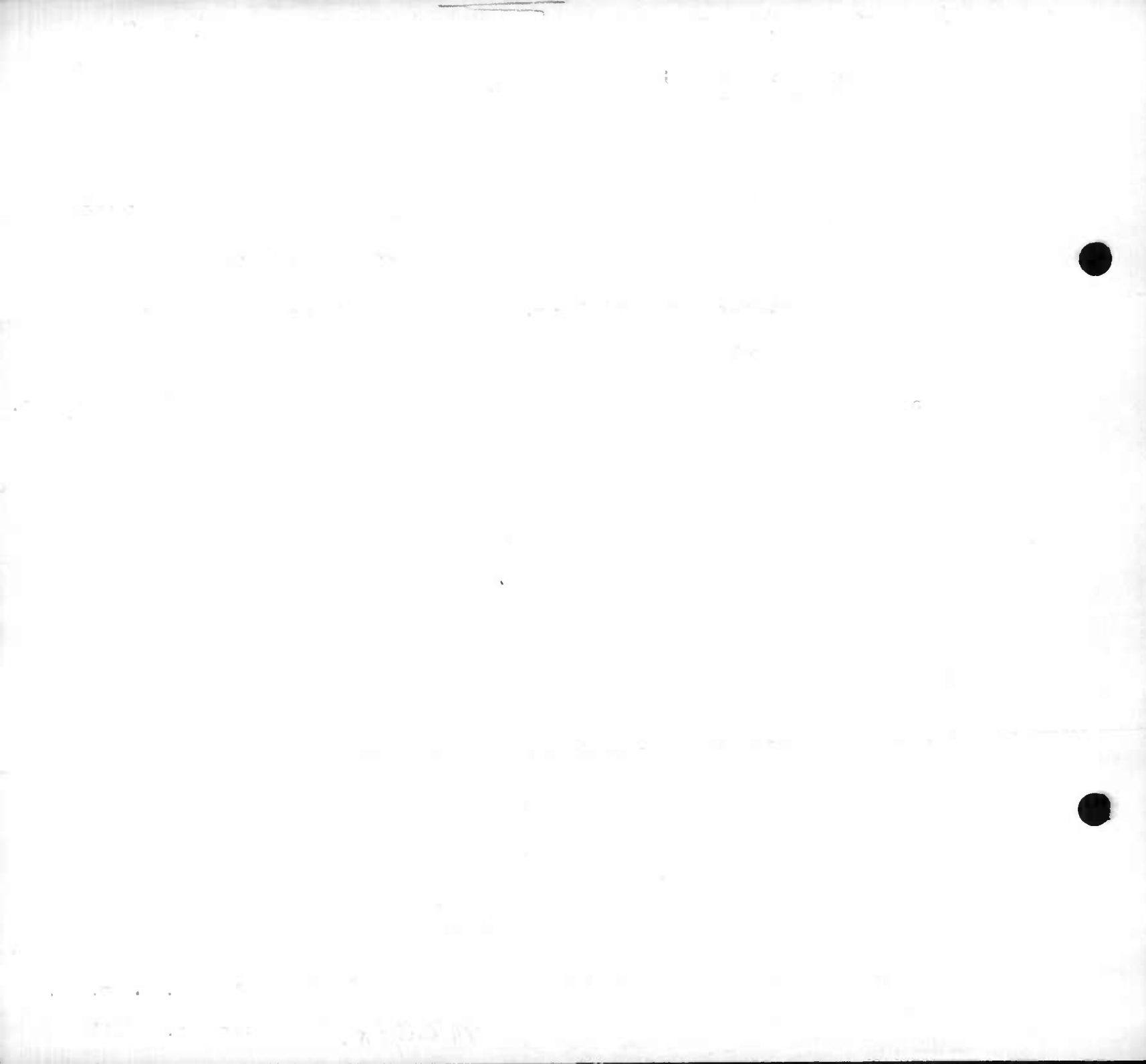
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3347</b>	
K-520 70 3347		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>FANNIE F KING</b>		2. DATE AND HOUR OF DEATH <b>MARCH 29 1970</b> <span style="float: right;">A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Gould's Nursing Home</b>		C. CITY OR TOWN <b>Parkville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3008 Taylor Ave</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 14 1880</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Land Lady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Boarding House</b>	9. AGE (In years last birthday) <b>89</b>
11. BIRTHPLACE (State or foreign country) <b>Penn</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Famous</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Hornberger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-38-254</b>	17. INFORMANT <b>Beculah King</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CARCINOMA OF THE COLON &amp; METASTASIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mos</b>	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD</b>			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/24 1964</b> to <b>3/29 1970</b> , that (I) (we) lost saw the deceased alive on <b>3/28 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>L.P. Berger MD</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <b>3/30/70</b>
23C. PHYSICIAN'S NAME (Type) <b>L-P. BERGER MD</b>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>APR 1, 1970</b>	24C. NAME OF CEMETERY or CREMATORY <b>Water's Memorial Mt. Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>HARTFORD CO. MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b>	25C. FUNERAL DIRECTOR <b>Charles F. Evans</b>	
		ADDRESS <b>8802 Hartford Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

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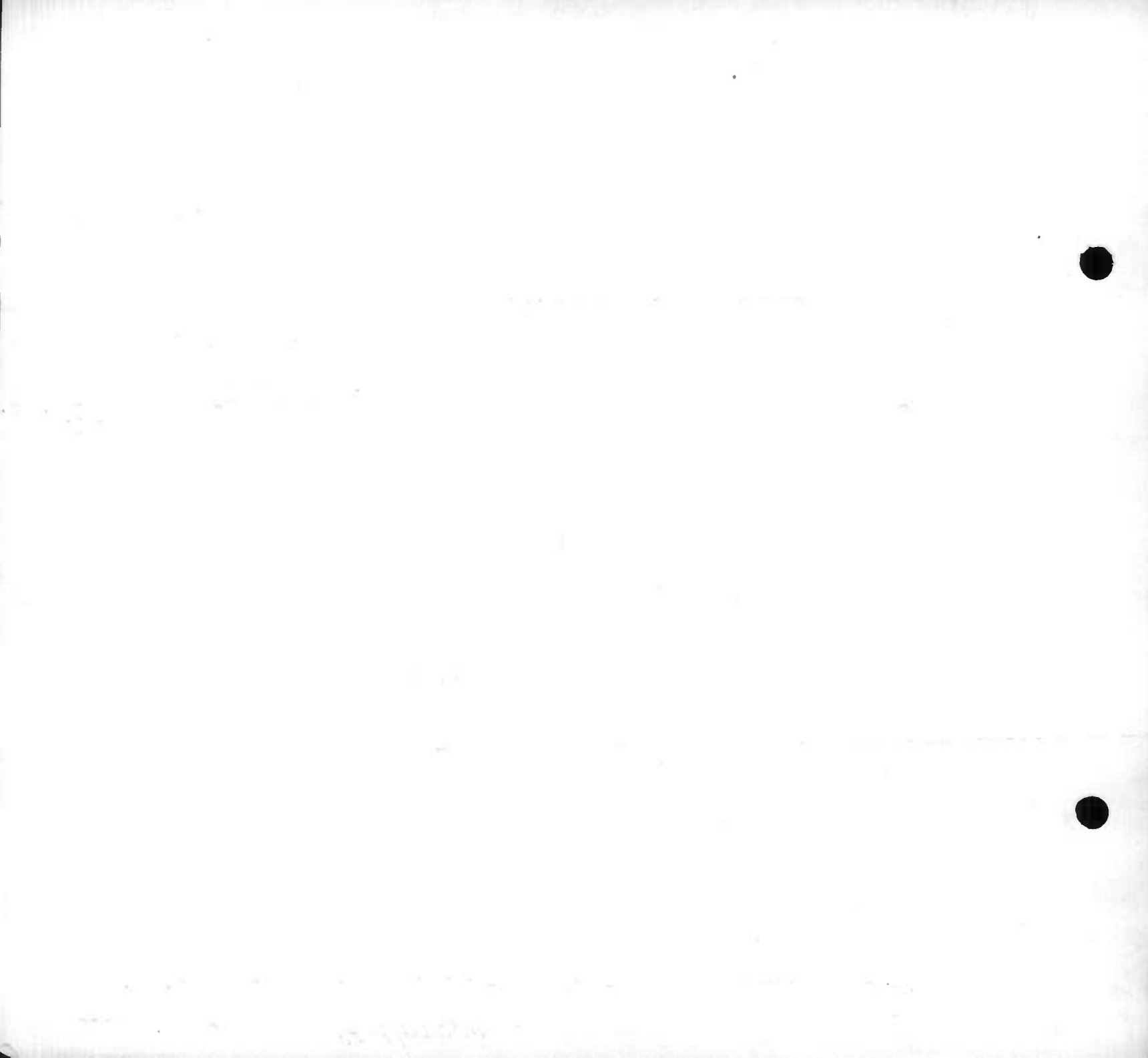
K-145		70 3348		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3348	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <del>John Thomas</del> KOPPELMAN : John Thomas			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 3-29-70 15:20 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Balto Gen Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 25-44		C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Watchman		10B. KIND OF BUSINESS OR INDUSTRY Lyon Conklin Co.		9. AGE (In years last birthday) 78		11. BIRTHPLACE (State or foreign country) md. (Baltimore)	
13. FATHER'S NAME Koppelman				12. CITIZEN OF WHAT COUNTRY? U S			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME Unknown		17. INFORMANT (FRIEND) Mrs. Shaw	
16. SOCIAL SECURITY NO.				ADDRESS 804 Pontiac Ave. 21225			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2-25-70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED moribund 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 2-25-1970 to Mar 29 1970 that (I) (we) last saw the deceased alive on Mar 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 3-29-70 23C. PHYSICIAN'S NAME (Type) NAPOLEON P. ABANDO 23D. ADDRESS 3001 S. HANOVER ST. BALT. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/1/70 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill 24D. LOCATION (City, town, or county) (State) Ritchie Highway A. A. Co. Md. 25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR McCall F.H. 25D. ADDRESS 237 Patapsco Ave. 21225							



# FUNERAL DIRECTOR: IMPORTANT

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B-200 70 3349				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3349	
1. NAME OF DECEASED (Type or Print) <b>EMIL BUSCH</b>				2. DATE AND HOUR OF DEATH <b>3-27-70 8:35 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> C. CITY OR TOWN <b>Pasadena</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Route 11 Box 116-B Venice on the Bay</b>					
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-05</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Truck driver &amp; electrician</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Mathison Chemical</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Emil Busch</b>				14. MOTHER'S MAIDEN NAME <b>Louise Schneider</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ethel Busch</b>			ADDRESS <b>Route 11 Box 116B Pasadena, Md.</b>		
18. <b>519.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic Pulmonary</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>COPD, pulmonary fibrosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-1-70</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-25</b> 19 <b>70</b> to <b>3-27</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-27</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Virginia Y. Faust M.D.</b>				23B. DATE SIGNED <b>3-27-70</b>			23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA Y. FAUST M.D.</b>		
23D. ADDRESS <b>South Baltimore General Hospital</b>				23E. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/31/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey Howard Co. Md.</b>			
25A. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>				25B. FUNERAL DIRECTOR <b>Mcally FH</b>		25C. ADDRESS <b>237 Patapsco Ave. 21225</b>			

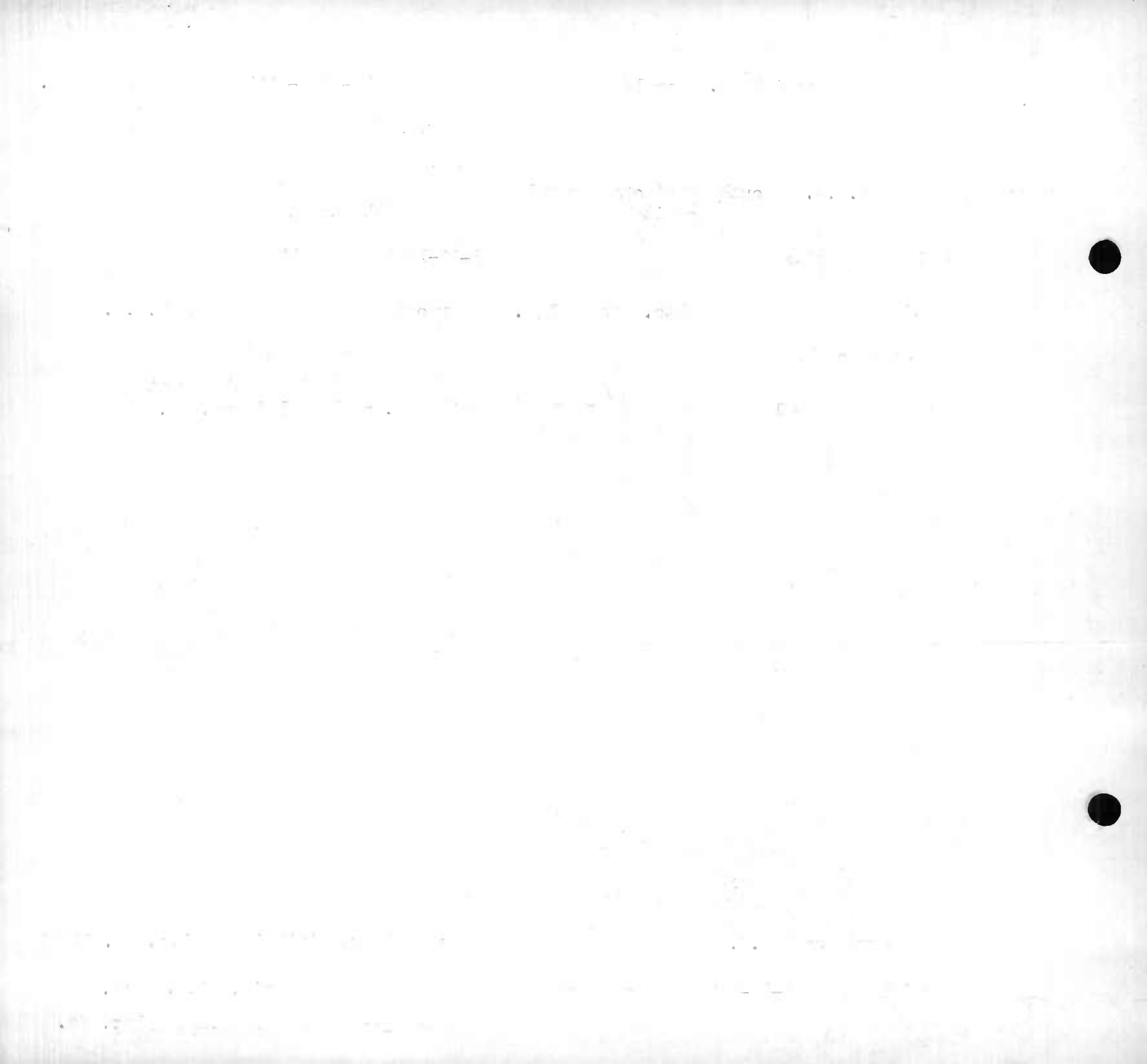




FUNERAL DIRECTOR: IMPORTANT

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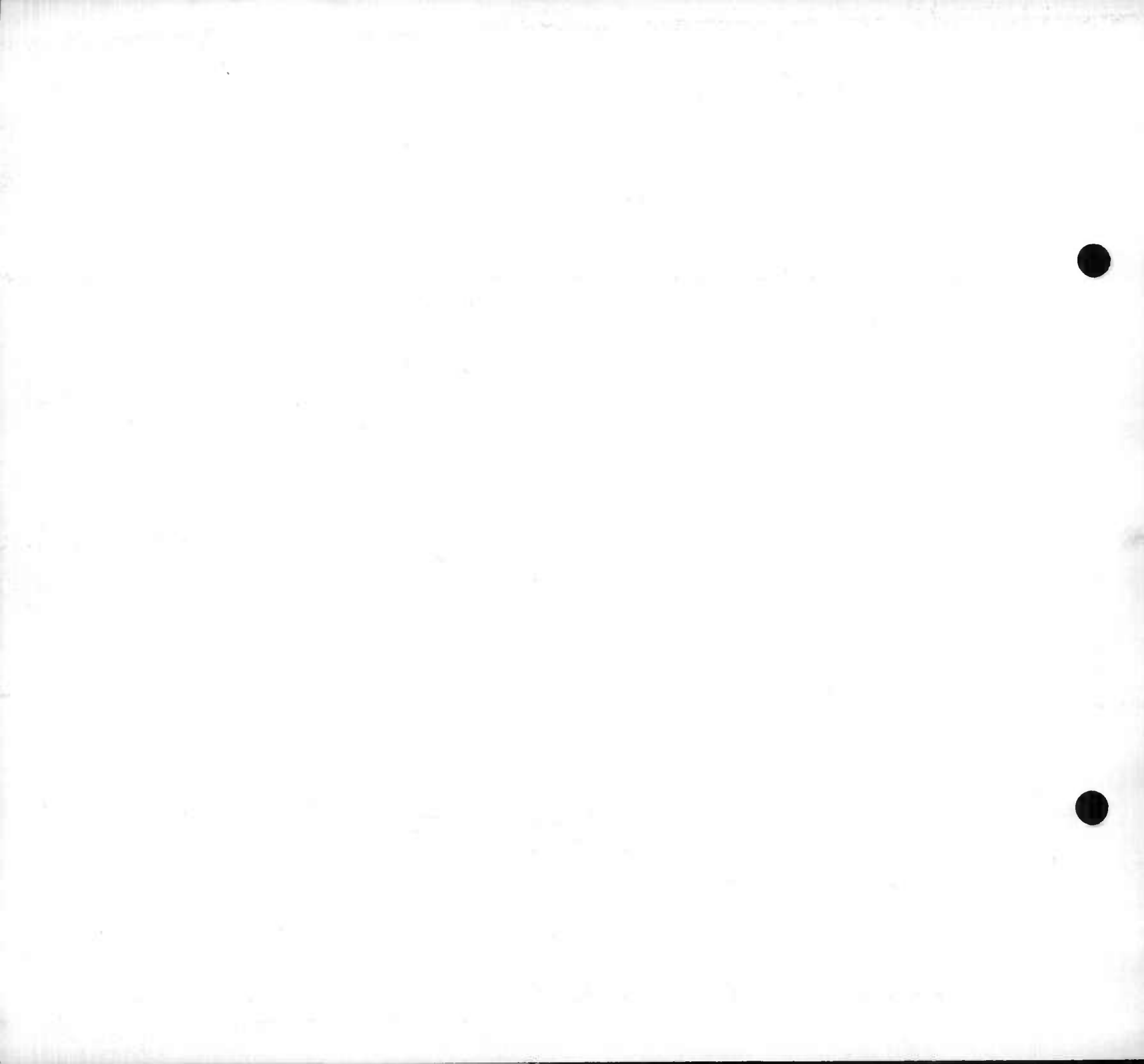
BALTIMORE CITY HEALTH DEPT.				REG. NO. <span style="font-size: 1.2em;">70 3350</span>	
1. NAME OF DECEASED (Type or Print) <b>Frederick C. Donald</b>			2. DATE AND HOUR OF DEATH <b>3 - 26 - 1970</b> <span style="float: right;">p. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <span style="float: right;"><b>25-34</b></span>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>43</b> <b>99 (D.O.A.) South Baltimore General Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3808 6th Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1893</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months   Days   Hours   Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Elec.</b>		11. BIRTHPLACE (State or foreign country) <b>Vermont</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Donald</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Jane (Rae)</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		
16. SOCIAL SECURITY NO. <b>212-05-5731</b>			17. INFORMANT <b>3808 6th Street</b> <b>Lucille V. Donald Baltimore, Md. 21225</b>		
18. CAUSE OF DEATH <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary arteriosclerosis</b> <b>Chronic congestive heart failure</b> <b>pulmonary emboli</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>12 yrs</b> <b>3 yrs</b> <b>1 yr</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1958</b> 19 <b>Mar. 26</b> 19 <b>70</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Mar. 19</b> 19 <b>70</b> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Harry B. Scott</b> DEGREE				23B. DATE SIGNED <b>3-28-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harry Scott M.D.</b> DEGREE				23D. ADDRESS <b>Medical Arts Building Balto. Md. 21201</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-30-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, (A.A.) Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>			
25B. NAME OF REGISTRAR <b>Philip E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>McCully-237 Patapsco Avenue Balto. Md. 21225</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

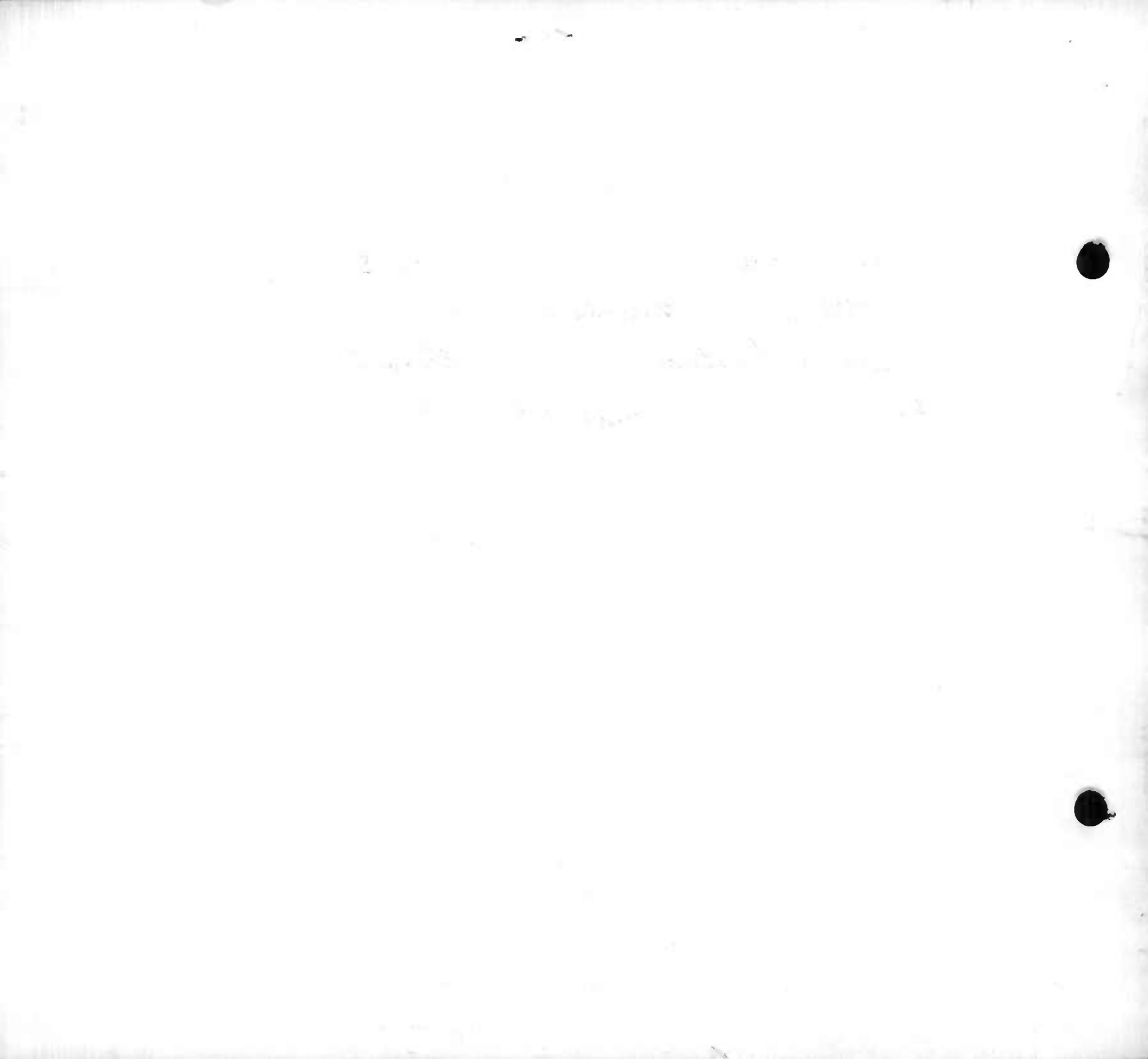
G-350 70 3351				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3351	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lillian R. Godwin</u>				2. DATE AND HOUR OF DEATH <u>3/29/70</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Ind.</u> B. COUNTY <u>21-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>836 Woodward St.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/22/1905</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ziginiski</u>				14. MOTHER'S MAIDEN NAME <u>Rose Savage</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>2-5-01-8149</u>		17. INFORMANT <u>Dorothy L. Leitz</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>2-5-01-91</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Hypertensive Arteriosclerosis</u> 20 years			
				(C) <u>Diabetes Mellitus</u> 27 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>Dec 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Amputation right leg</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>51</u> to <u>3/29</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/23</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John P. Urlock Jr.</u>				23B. DATE SIGNED <u>3/30/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR MD</u>				23D. ADDRESS <u>1227 Washington Blvd Baltimore Md 2120</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Brown &amp; Son Inc.</u>		ADDRESS <u>2233 E. St. Baltimore Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3352</b>	
S-135 70 3352		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SUBOTNIK, AARON</b>		<b>3-28-70 17:10 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI - HOSPITAL OF BALTIMORE</b>		A. STATE <b>BALTIMORE</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
<b>42</b>		<b>3410 ROCKWOOD AVE #15 BALT. Md.</b>	
		C. CITY OR TOWN	
		<b>BALTIMORE</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER	
		<b>3410 ROCKWOOD AVE 27-19</b>	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<b>Male</b>	<b>White</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>9/12/95</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
<b>Retired</b>		<b>74</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Merchant</b>		<b>RUSSIA</b>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY	
<b>David Subotnik</b>		<b>RUSSIA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME	
<b>No</b>		<b>Riska?</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT	
<b>219-14-1058</b>		<b>WIFE</b>	
		ADDRESS	
		<b>SAME</b>	
18. <b>410.0 I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE	
ANTECEDENT CAUSES		<b>CORONARY THROMBOSIS</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
		(B) <b>HCVD.</b>	
		DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<b>3-24-70</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <b>3/22/70</b> 19 <b>70</b> to <b>3/28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE			23B. DATE SIGNED
<b>Philip S. Yutan M.D.</b>			<b>3/28/70</b>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS
<b>PHILIP S. YUTAN M.D.</b>			<b>Sinai - Hospital of Baltimore</b>
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/29/70</b>	<b>Bed Isaac Adath Israel</b>	<b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
<b>MAR 31 1970</b>	<b>Philip S. Yutan, M.D.</b>	<b>Sal. Furman, M.D.</b>	<b>6010 Reisterstown Rd.</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>K-625</b>      <b>70</b>      <b>3353</b></p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b>      <b>REG. NO. 70 3353</b></p>					
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print)      <b>JACK KERSHMAN</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> 3-27-1970      6:20 P.M. M.</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE      B. COUNTY MARYLAND      Baltimore      53-00</p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL 730 ARHURTON ST. BALTIMORE.</p>				<p><b>C. CITY OR TOWN</b>      <b>D. INSIDE CITY LIMITS?</b> BALTIMORE      YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>E. STREET AND NUMBER</b> 3510 WASHINGTON AVE.</p>					
<p><b>5. SEX</b> MALE</p>	<p><b>6. RACE</b> WHITE</p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> 1-1-07</p>	<p><b>9. AGE</b> (In years lost birthday)      63</p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) RUSSIA</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) EMPLOYEE</p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> MEAT PACKING CO.</p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.</p>	
<p><b>13. FATHER'S NAME</b> AARON KERSHMAN</p>			<p><b>14. MOTHER'S MAIDEN NAME</b> ETHEL FLEISCHER</p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p><b>16. SOCIAL SECURITY NO.</b> 216-03-6018A</p>		<p><b>17. INFORMANT</b>      <b>ADDRESS</b> MR. ABE KERSHMAN, 6600 CHIPPEWA DRIVE #21209</p>	
<p><b>18. CAUSE OF DEATH</b></p>					
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC FAILURE</b></p>					
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <b>CARCINOMA OF COLON with METASTASIS IN LIVER &amp; Right Lung.</b></p>					
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>DEEP VAUNDICE</b></p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from 3-3-1970 to 3-27-1970, that (I) (we) last saw the deceased alive on 3-27-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <i>Red al M.B.B.S.</i></p>				<p><b>23B. DATE SIGNED</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) PREM LAL M.B.B.S.</p>				<p><b>23D. ADDRESS</b> LUTHERAN HOSPITAL 730 ARHURTON ST. BALTIMORE</p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) BURIAL</p>		<p><b>24B. DATE</b> 3-29-70</p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b> HEBREW YOUNG MEN</p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) BALTIMORE, MARYLAND</p>					
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> MAR 31 1970</p>		<p><b>25B. NAME OF REGISTRAR</b> E. J. [Signature]</p>		<p><b>25C. FUNERAL DIRECTOR</b>      <b>ADDRESS</b> SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</p>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">15-122</span>	
C-500 70 3354				70 3354	
BIRTH NO.				70 3354	
1. NAME OF DECEASED (Type or Print) <b>COHEN - LENA</b>			2. DATE AND HOUR OF DEATH <b>3/28/70</b> at <b>2.40 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTIMORE</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>6512 PARK HEIGHT</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/87</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>PHILIP KADER</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MR. SIDNEY E. COHEN, 2304 KEN OAK RD.</b>		
18. <b>322 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-RESPIRATORY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>? CEREBRO- VASCULAR ACCIDENT</b> <b>? ENCEPHALITIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/23/1970</b> to <b>3/28/1970</b> that (I) (we) last saw the deceased alive on <b>3/28/1970</b> and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>			23B. DATE SIGNED <b>3/28/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. NEELAM KAPOOR</b>			23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-29-70</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

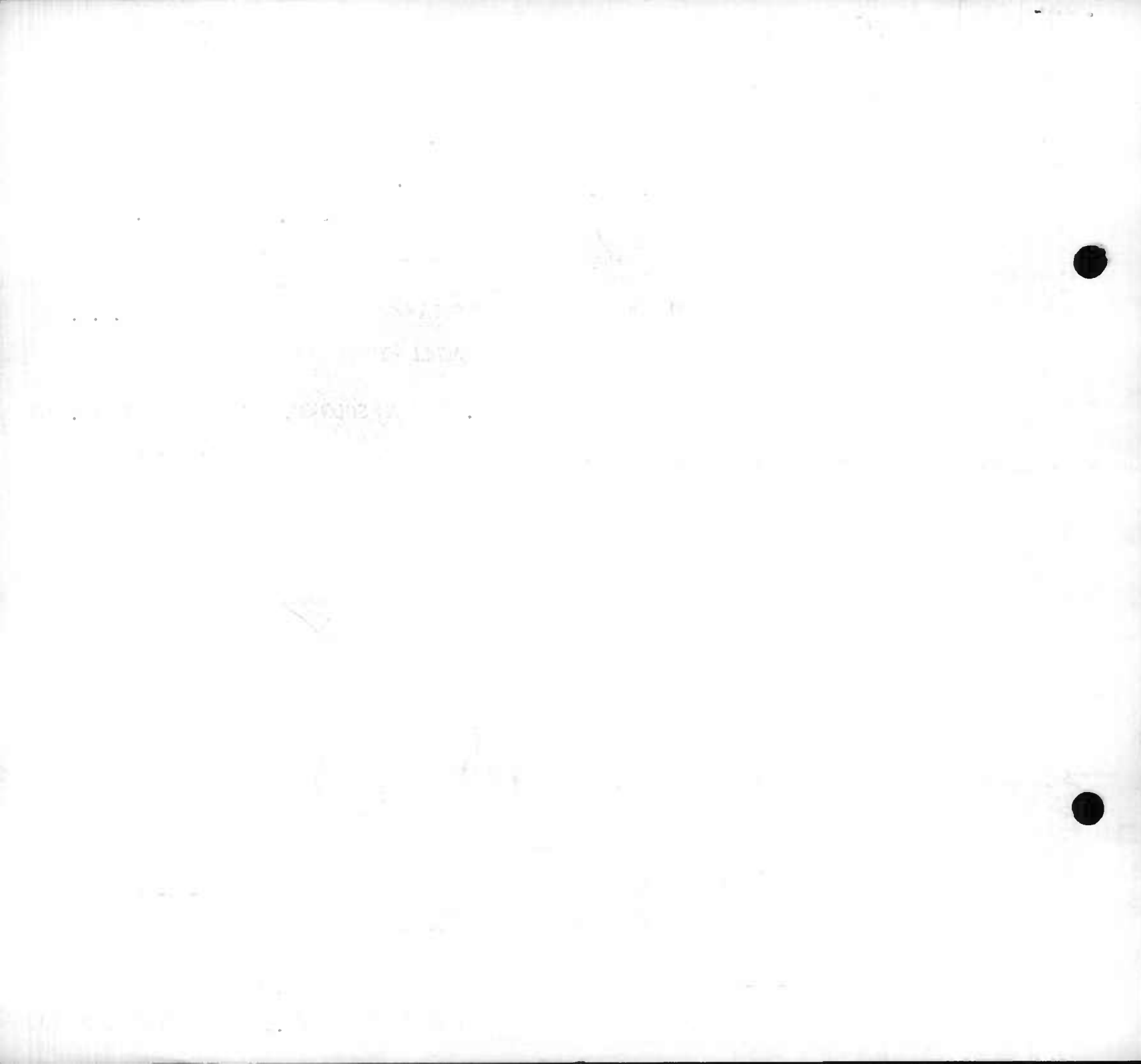
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-455 70 3355		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3355	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TILLIE XXXXXX Solomon</b>		2. DATE AND HOUR OF DEATH <b>3-27-1970</b> <span style="float: right;">4 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-19</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital, Inc.</b>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5815 XXXXXXXXXXXX ETHELBERT AVE. #15</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-1896</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RUBIN LEVINE</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL MINNIE SMITH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N O</b>		17. INFORMANT <b>MR. ABRAHAM SOLOMON, 5815 ETHELBERT AVE. #15</b>	
18. <b>203 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>multiple myeloma</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2) Anemic</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-1970</b> to <b>3-27-1970</b> that (I) <del>was</del> last saw the deceased alive on <b>3-27-1970</b> and that (in my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>H. MAKPOU</b>		23B. DATE SIGNED <b>3-27-70</b>		23C. PHYSICIAN'S NAME (Type) <b>HOUSHANG - MAKPOU</b>	
23D. ADDRESS <b>MERCY HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-29-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>2222 E. J. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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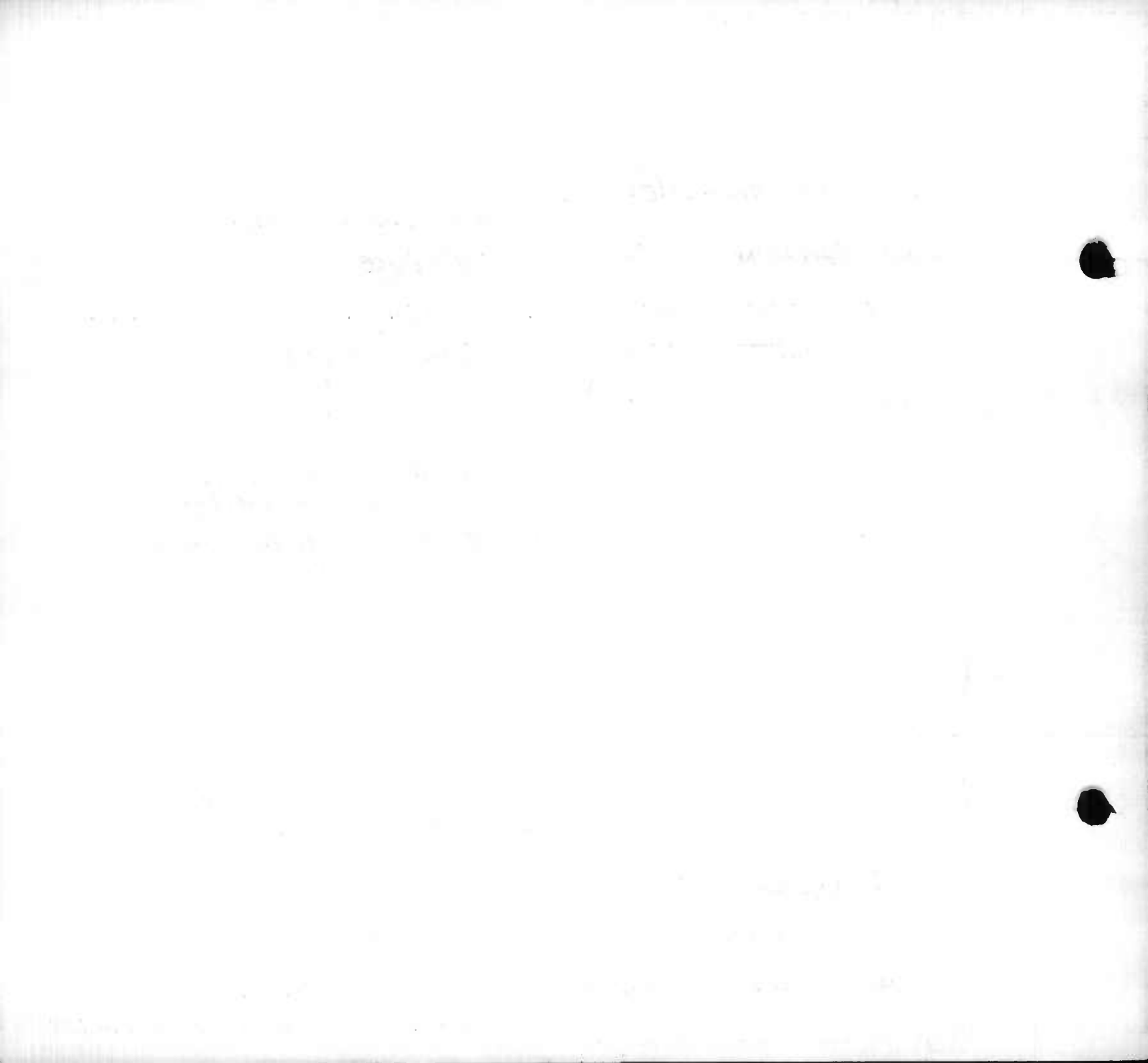
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3356</b>	
H-143 70 3356		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Charles Hoffeld</b>	
2. DATE AND HOUR OF DEATH <b>March 29, 1970 12:25 A. M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Jenkins Memorial</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>	
C. CITY OR TOWN <b>Rossuville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>Rt/#2 Box 284 Ridge Rd.</b>		5. SEX <b>Male</b> 6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>1-3-1881</b> 9. AGE (In years lost birthday) <b>89</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Independent Oil</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard</b>		14. MOTHER'S MAIDEN NAME <b>Scholastica Michaels</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>219-30-4821</b>	
17. INFORMANT <b>Jenkins Memorial 1000 Caton Ave., 21229</b>		ADDRESS	
18. <b>4/10/9</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Obstructive Pulmonary Disease</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>DEC 8 1969</b> to <b>MARCH 29 1970</b> , that <del>the</del> (we) lost saw the deceased alive on <b>MAR 29 1969</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>John F. Hartman M.D.</b>		23B. DATE SIGNED <b>MAR 29, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN F. HARTMAN M.D.</b>		23D. ADDRESS <b>Jenkins Memorial Hosp. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-31-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Crash Funeral Home</b>		ADDRESS <b>2111 Chesaco</b>	



# FUNERAL DIRECTOR: IMPORTANT

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A-620 70 3357		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3357	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Melvin C. Ayres</u>		2. DATE AND HOUR OF DEATH <u>9 am 2/27/1970</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-35</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3112 Glendale Avenue</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05-05-06</u>	9. AGE (In years lost birthday) <u>63</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>American Can Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>WILLIAM AYER Ayres</u>		14. MOTHER'S MAIDEN NAME <u>SARAH WEBB</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>WIFE</u> ADDRESS <u>the same</u>	
18. <u>160.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pericarditis</u> <u>hypertension</u> <u>ischemic heart disease</u> (B) <u>Ca of unidentified type in pericardial region</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> 19 <u>70</u> to <u>3/27</u> 19 <u>70</u> that (I) <u>we</u> last saw the deceased alive on <u>3/27</u> 19 <u>70</u> and that (in my <u>best</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Van Hammen</u> MD.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>DR. VAN HAMMEN MD</u>	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>John C. Miller Inc- 6415 Belair Rd.-21206</u>	

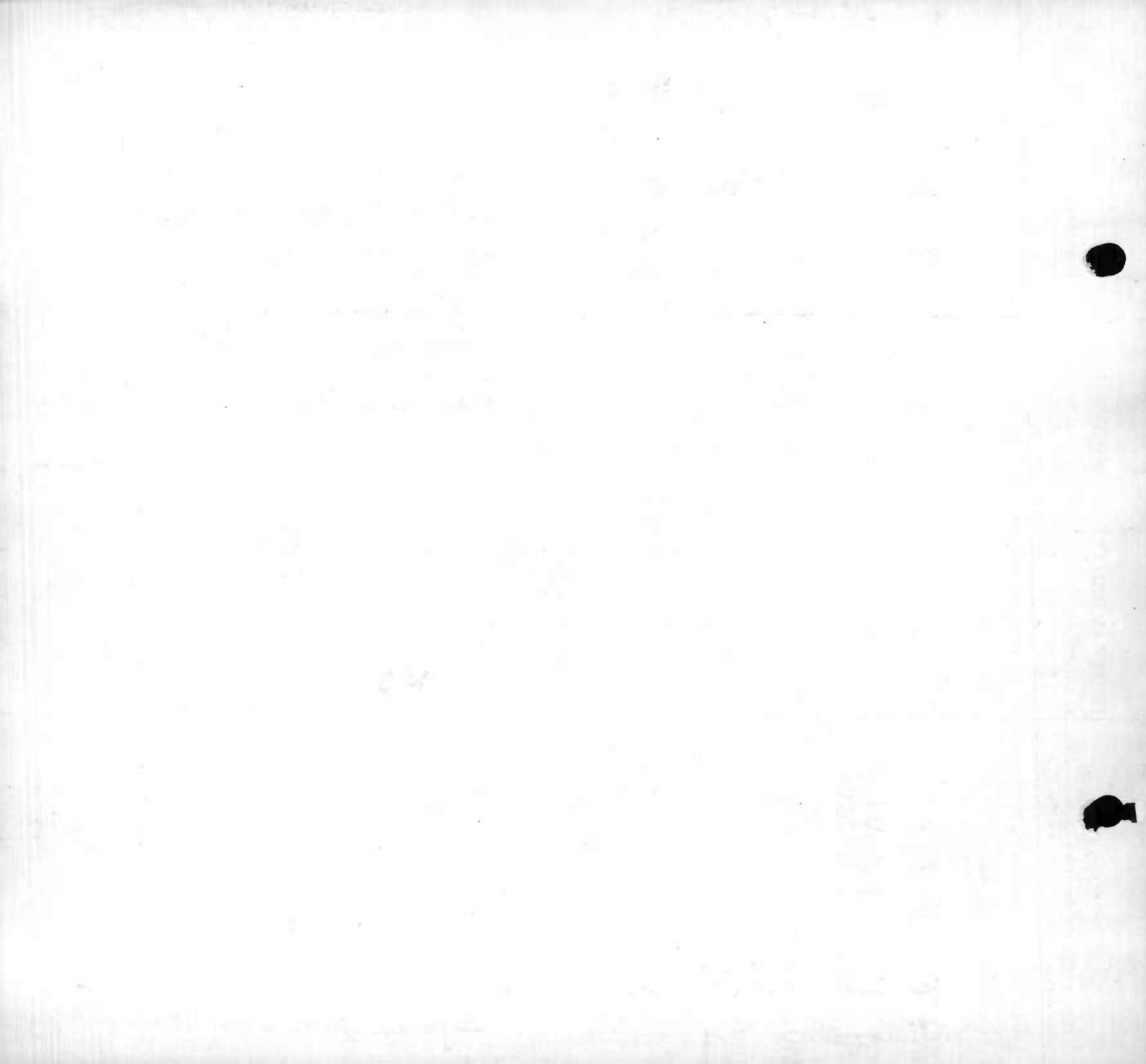




# FUNERAL DIRECTOR: IMPORTANT

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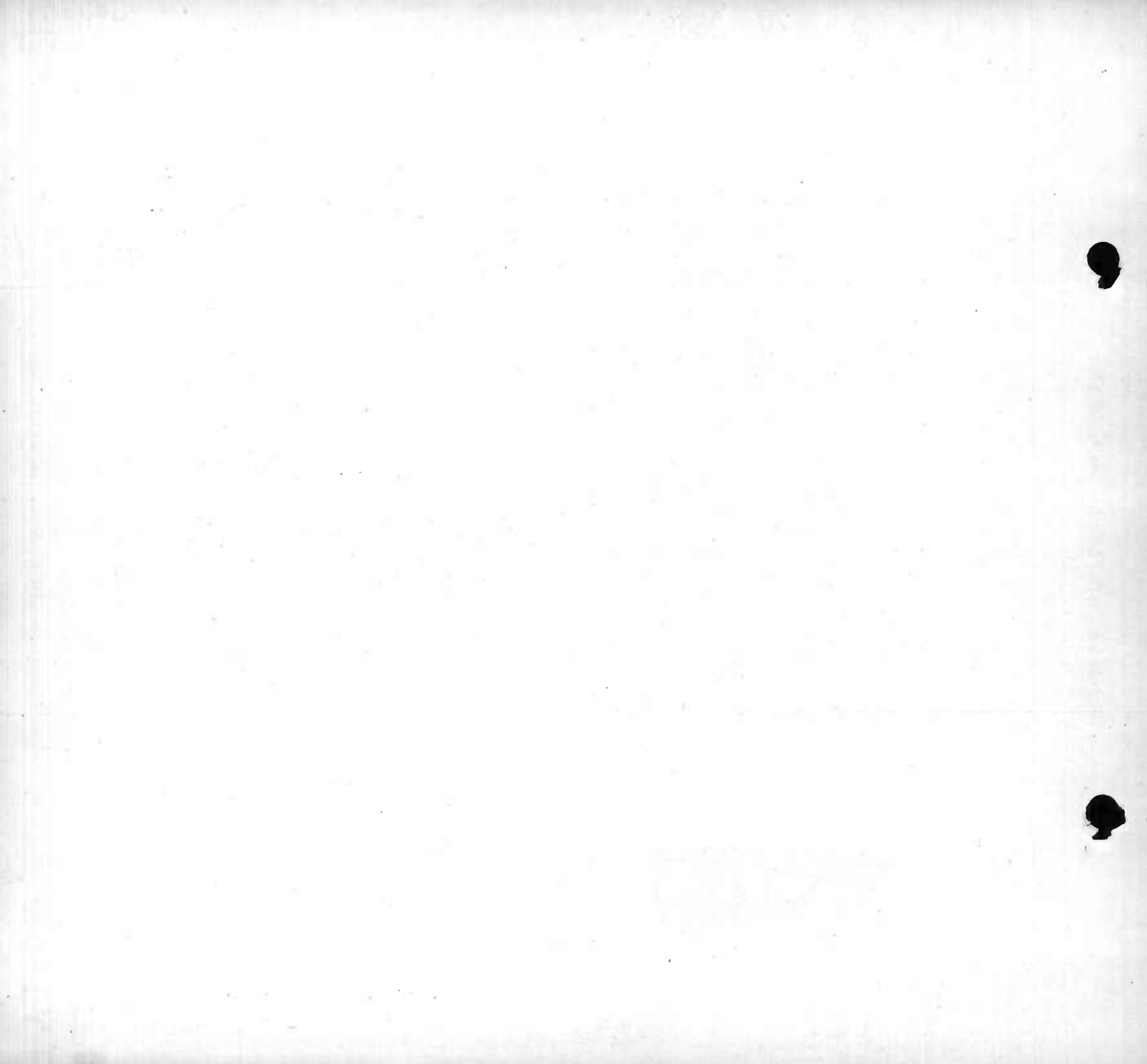
J-255 70 3358				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3358	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Leo JACHMAN</b>		2. DATE AND HOUR OF DEATH <b>3/29/1970 11:30 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-19</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hosp 42</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3800 PRIMROSE AVE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 15, 1893</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Sun Papers</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH</b>				14. MOTHER'S MAIDEN NAME <b>ETHEL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS LEAH JACHMAN</b>		ADDRESS <b>SAME</b>	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary atherosclerosis</b> <b>Hypertensive C.V.D.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Hour</b> <b>5 yrs.</b> <b>15 yrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct. 1952</b> to <b>March 29 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3/11 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. <b>DOA - Sinai Hospital</b>							
23A. SIGNATURE <b>Louis E. Wice M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>LOUIS E. WICE</b>				23D. ADDRESS <b>920 ST. PAUL ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/31/1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Adams Chapel</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Blair E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Sylvan Louis &amp; Son</b>		ADDRESS <b>9610 Reisterstown Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

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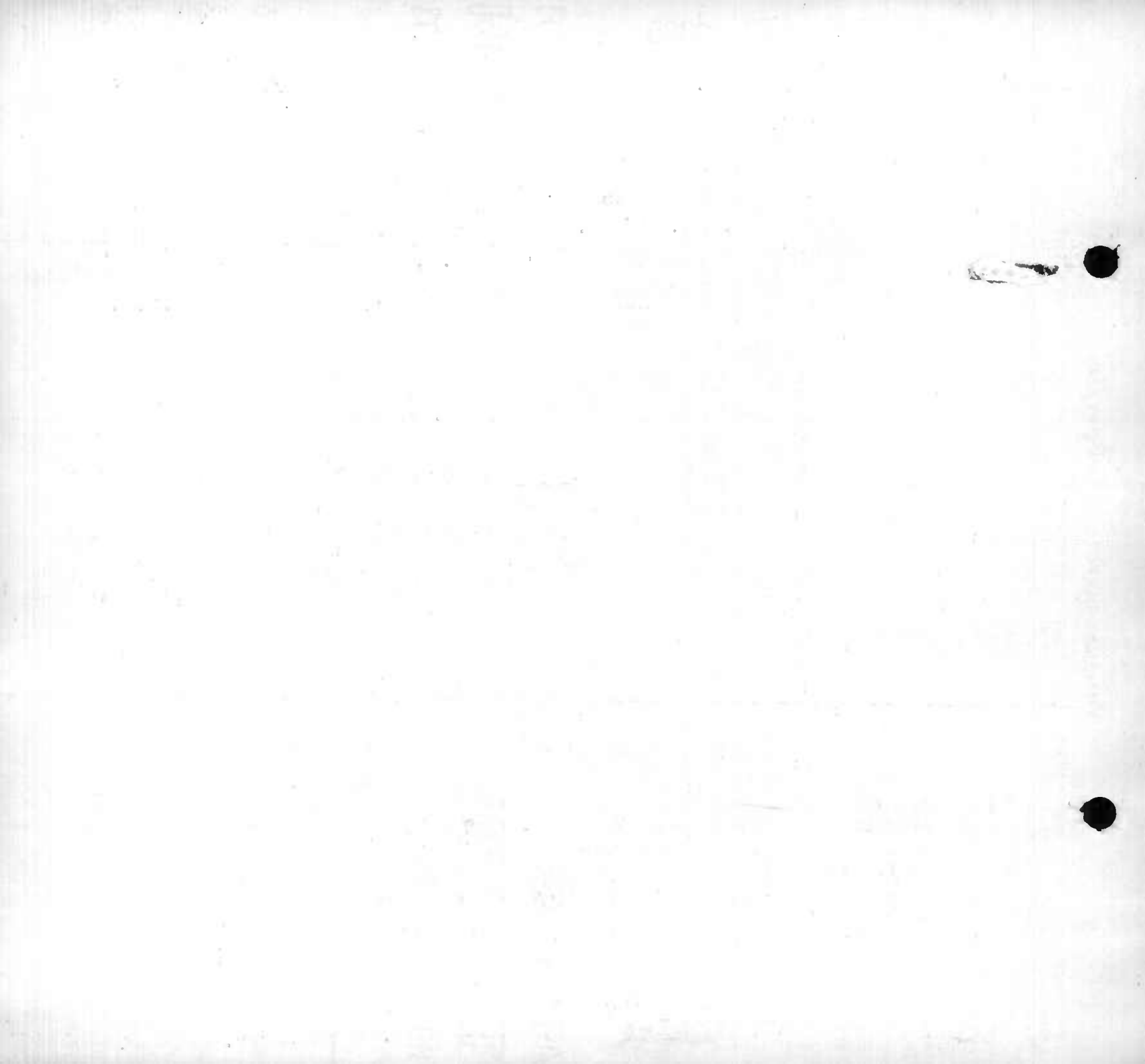
P-620 70 3359		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3359	
BIRTH NO. 70-04173		1. NAME OF DECEASED (Type or Print) Cynthia Pearce		2. DATE AND HOUR OF DEATH 3/28/70 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 13-48			
FULL NAME OF HOSPITAL OR INSTITUTION 33 601 N. BROADWAY JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1475 ROLAND HEIGHTS AVE.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/70	9. AGE (In years last birthday) 19	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick C. Pearce		14. MOTHER'S MAIDEN NAME PATRICIA SLENAKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Patrick C. Pearce - 1475 Roland Hghts. Ave.	
18. 75-1.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) Renal failure (C) Duodenal atresia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 24 hours 19 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal atresia		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 10, 1970 to March 28, 1970, that (I) (we) lost the deceased alive on March 28, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David G. Ansel M.D.				23B. DATE SIGNED 3/28/70	
23C. PHYSICIAN'S NAME (Type) DAVID G. ANSEL M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/30/70		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gard.	
24D. LOCATION (City, town, or county) Balto. Co.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Ann Donovan - 3818 Roland Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

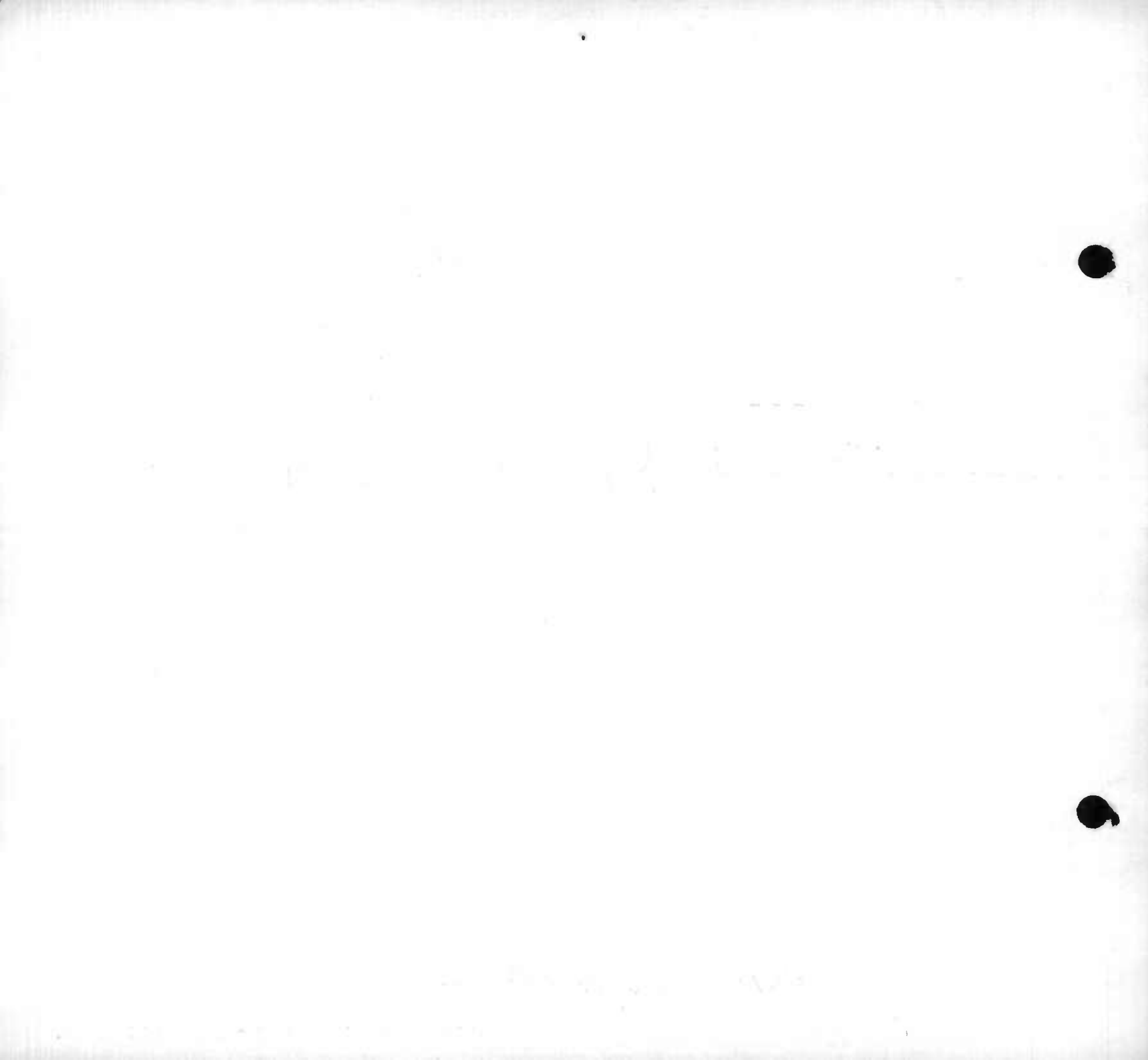
W-300 70 3360		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3360	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Sadie W. Wade</i>		2. DATE AND HOUR OF DEATH <i>March 28 1970 3:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Edgewood Nursing Home Bolona Aven at Belvedere Baltimore, Md. 21212</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
S. SEX <i>F</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <i>formerly 514 Rosehill Terrace</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY ---		8. DATE OF BIRTH <i>Oct. 3, 1886</i>	
13. FATHER'S NAME <i>William Walters</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Baker</i>		9. AGE (In years lost birthday) <i>73 Yrs.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-5988</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
17. INFORMANT <i>Mrs. Frances Wade</i>		ADDRESS <i>4611 Elsrode Avenue</i>			
18. <i>281.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pernicious Anemia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic C.V. disease</i> (B) <i>also</i> (C) <i>Osteoporosis &amp; bone degeneration</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i> <i>15 yrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 27 1962</i> to <i>March 28 1970</i> , that (I) <i>we</i> last saw the deceased alive on <i>March 27 1970</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> (did not) view the body after death.					
23A. SIGNATURE <i>H.V. Harbold M.D.</i>		23B. DATE SIGNED <i>March 30, 1970</i>			
23C. PHYSICIAN'S NAME (Type) <i>H.V. HARBOLD M.D.</i>		23D. ADDRESS <i>4706 Harford Road - 21214</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/30/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 31 1970</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>	
25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
L-200 70 3361		70 3361		70 3361	
1. NAME OF DECEASED (Type or Print) <b>LEWIS, WELLER, ROSS B.</b>		2. DATE AND HOUR OF DEATH <b>3/27/70 10 57 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Dorchester Co.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL 38</b>		C. CITY OR TOWN <b>HOOPERSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>None</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/6/15</b>	9. AGE (In years last birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watson</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JAMES LEWIS</b>			
14. MOTHER'S MAIDEN NAME <b>FLOY WINDSOR</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No - - -</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>			
18. <b>5 27 01</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Shock, septic</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Pseudomonas (E. coli) &amp; acute pancreatitis</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Acute renal failure &amp; pulmonary edema</b>			
19A. DATE OF OPERATION <b>3/24/70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>acute abdomen</b>	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>3/22/70</b> 19 to <b>3/27</b> 1970 that (I) (we) last saw the deceased alive on <b>3/27</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vicente R. Carag Jr. M.D.</b>		23B. DATE SIGNED <b>3/27/70</b>		23C. PHYSICIAN'S NAME (Type) <b>VICENTE R. CARAG JR. M.D.</b>	
23D. ADDRESS <b>University Hospital</b>		23E. DEGREE <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/30/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>John E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Md.</b>	

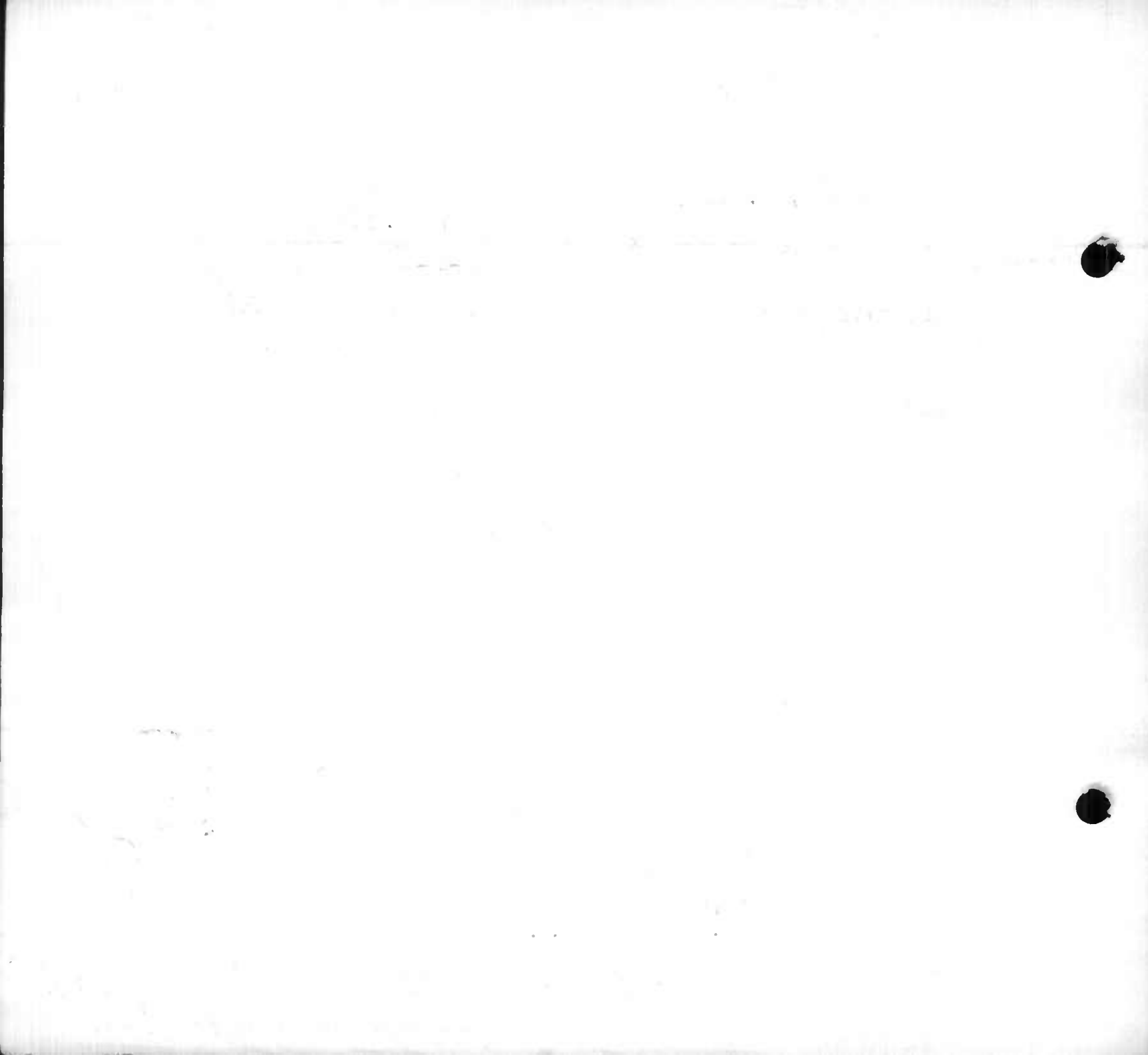




# FUNERAL DIRECTOR: IMPORTANT

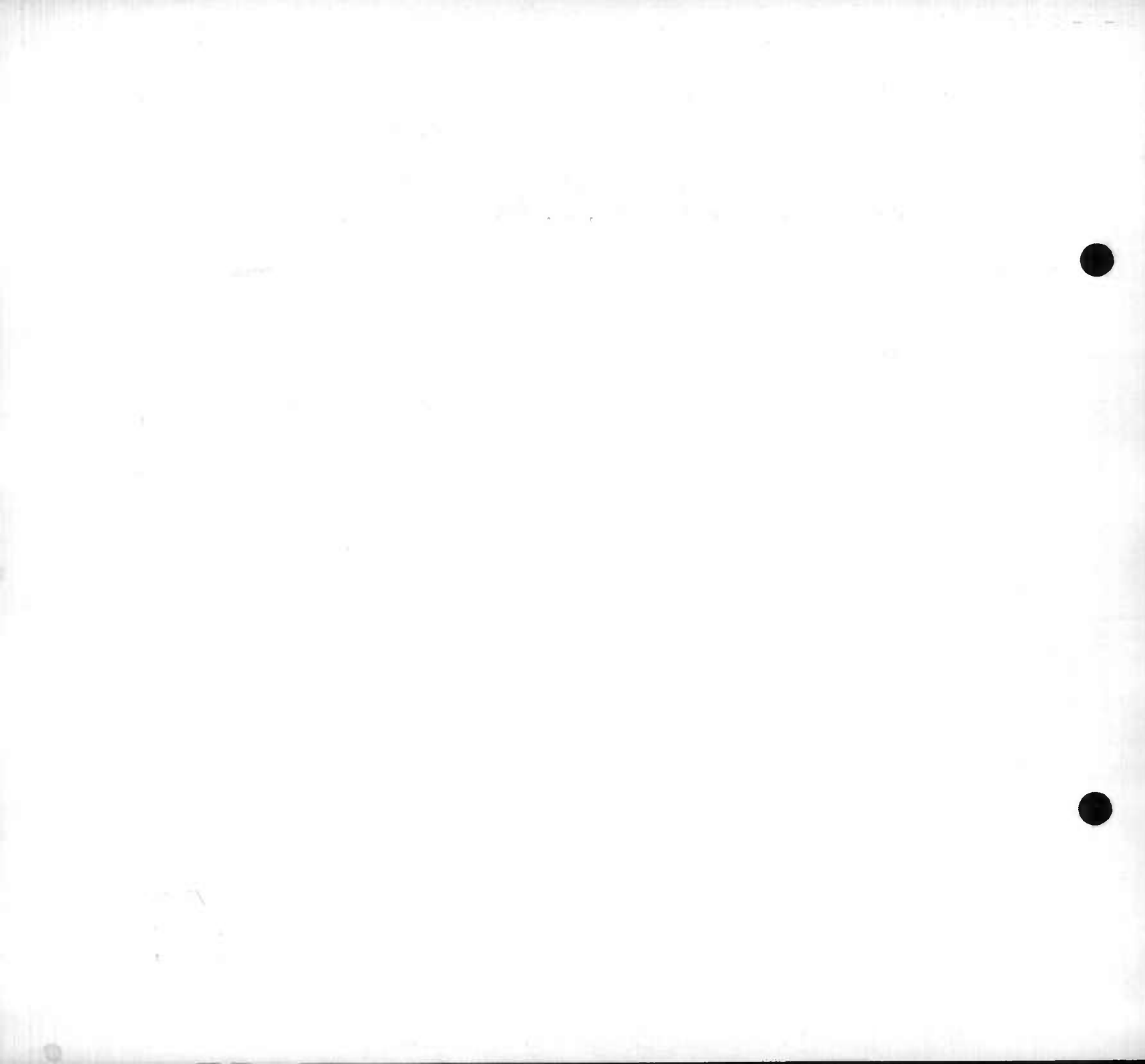
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-260 70 3362		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3362	
BIRTH NO.		NIGRO		2. DATE AND HOUR OF DEATH 3/28/70 11:59 AM	
1. NAME OF DECEASED (Type or Print) <i>Elith Nigin</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>DELAWARE</i> B. COUNTY <i>V-07</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD. 21205</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>WILMINGTON</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>7 E. 3RD STREET</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>08-10-06</i>	9. AGE (In years last birthday) <i>63</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore-Md.</i>	
13. FATHER'S NAME <i>JESSE CARTER</i>		14. MOTHER'S MAIDEN NAME <i>ROSALEE CARTER</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp. Records</i> ADDRESS	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Massive acute myocardial infarct</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Intense atherosclerosis 20 yrs</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/26/70</i> to <i>3/28/70</i> that (I) (we) last saw the deceased alive on <i>3/28/70</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles S. Angell, M.D.</i> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/28/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHARLES S. ANGELL</i>		M.D.		23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-1-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery Wilmington Del.</i>	
24D. LOCATION (City, town, or county) (State) <i>Del.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 31 1970</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>	
25C. FUNERAL DIRECTOR <i>Wheaton Wilmington Del.</i>		ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-626 70 3363		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3363		X	
BIRTH NO. 70-05069				CERTIFICATE OF DEATH					
1. NAME OF DECEASED Type or Print PARKER BOY SUSIE				2. DATE AND HOUR OF DEATH 3/19/70 1 10 <sup>50</sup> PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. 53-00					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Balto City Hospital 21224 4940 Eastern Avenue Baltimore, Md.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 208 Diener Place		21229			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/70	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY? USA				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Carson Parker			14. MOTHER'S MAIDEN NAME Susie Powell			12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Baltimore City Hospitals Records 4940 Eastern Avenue Baltimore, Maryland				
18. 778.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Resp. arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary vs CNS hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/19 1970 to 3/19 1970 that (I) (we) last saw the deceased alive on 3/19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert Zeiger MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/19/70			
23C. PHYSICIAN'S NAME (Type) ROBERT ZEIGER MD				23D. ADDRESS Balto City H 4940 Eastern Avenue Baltimore, Maryland 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-25-70		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224			
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR P. E. Zeiger, Jr.		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3364</b>	
BIRTH NO. <b>70-0507470</b>		3364		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <b>Baby Boyce</b>			2. DATE AND HOUR OF DEATH <b>3-23-70 9:19 p.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BCH. 4940 Eastern Avenue Baltimore, Maryland 21224</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>802 W. Barre St., Balto. Md. 21220</b>					
5. SEX <b>M.</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Min. <b>48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>John Boyce</b>		14. MOTHER'S MAIDEN NAME <b>Alease Boyce</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>4940 Eastern Avenue Baltimore, Md. 21224</b> <b>BCH Records:</b>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia Neonatorum</b> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Fetal distress ?</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/23</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Partial Bruch extraction</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-23-70</b> to <b>3-23-70</b> 19 <b>70</b> to <b>3-23-70</b> 19 <b>70</b> and that in (my) ( <del>xxx</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>xxx</del> ) (did) ( <del>xxx</del> ) view the body after death.					
23A. SIGNATURE <b>Chen</b>			23B. DATE SIGNED <b>3/23</b>		
23C. PHYSICIAN'S NAME (Type) <b>TAO-MEI CHEN</b>			23D. ADDRESS <b>B. C. H. 4940 Eastern Ave. Balto., Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>3-25-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>	25B. NAME OF REGISTRAR <b>2260 3-23-70</b>	25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3365				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3365			
1. NAME OF DECEASED (Type or Print) Clark Hopie				2. DATE AND HOUR OF DEATH 3-25-70 11:35 a.m.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 13-04							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1717 Gwynn Falls Pkwy.											
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-12-1912		9. AGE (In years last birthday) 58		If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Shelby, North Carolina			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Anna Jeter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 220-07-9032				17. INFORMANT Mrs. Agnes Curtis Mullory -			
ADDRESS Same											
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3-16-70 19 to 3-25-70 19 that (I) (we) last saw the deceased alive on 3-25-70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3-25-70							
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS Provident Hospital, Inc. 514 Division Street - Baltimore, Maryland							
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3-30-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970				25B. NAME OF REGISTRAR Robert E. [Signature]				25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F. H. 1701 LAURENS ST.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70 3366</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>70 3366</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ELIZABETH M. JACKSON		March 29, 1970 8:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 3320 Foster Avenue			A. STATE Maryland 26-11		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3320 Foster Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH March 22, 1911	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Vogel		14. MOTHER'S MAIDEN NAME Caroline Rethman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Hannah Over 3320 Foster Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  73401 Sclerodermia -  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Nov. 27 1964 to 3/29 1970, that (I) (we) last saw the deceased alive on 3/25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto				23B. DATE SIGNED 3/30/70	
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO				23D. ADDRESS M.D. 3508 BAYVIEW ST - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-1970		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

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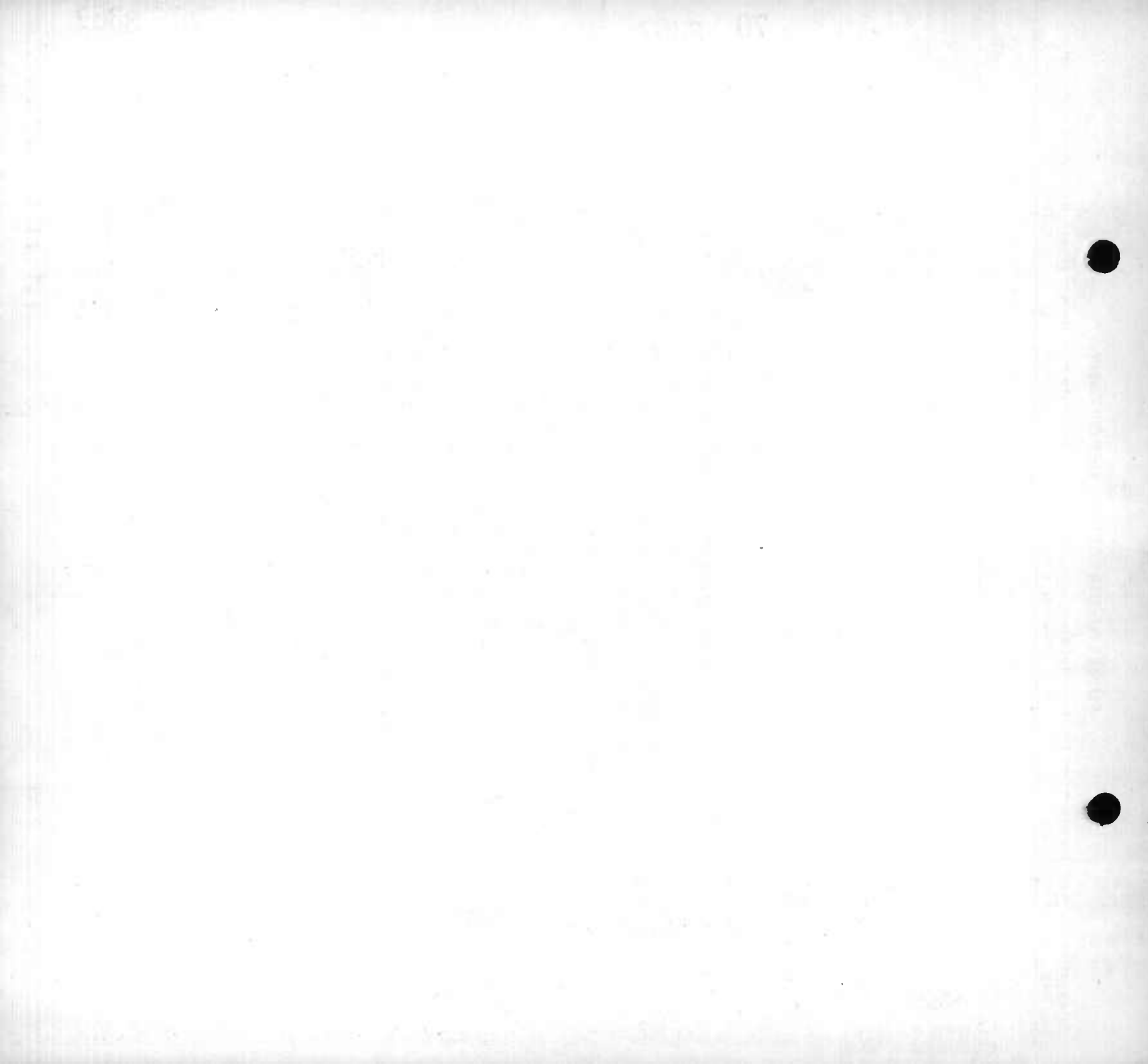
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3367</b>
M-200 70 3367		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>GEORGE ARTHUR MACKAY</b>		2. DATE AND HOUR OF DEATH <b>3/28/70</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>15-10</b> C. CITY OR TOWN <b>BAITO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3922 Dolfield Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>C.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 11, 1913</b>	9. AGE in years (last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK NEWS VA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>ARTHUR MACKAY</b>		
14. MOTHER'S MAIDEN NAME <b>RUBY SMITH</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>214-202065</b>		17. INFORMANT <b>ESTHER MACKAY</b> ADDRESS <b>3922 Dolfield Ave</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>PULMONARY Embolus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Suspected RENAL VEIN thrombosis</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>THROMBOPHLEBITIS, BILAT.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>NEPHROTIC Synd; GSCVD</b>		(C) <b>10 mo</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/4/1969</b> to <b>3/12/1970</b> , that (I) (we) last saw the deceased alive on <b>3/12/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) view the body after death.				
23A. SIGNATURE <b>F. L. BORGES MD</b>		23B. DATE SIGNED <b>3/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>F. L. BORGES MD</b>
23D. ADDRESS <b>1000 N. Highland Ave.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>3/31/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Ann Arundel Co. Md.</b>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Joseph M. Locks Jr.</b>		25C. FUNERAL DIRECTOR <b>1304 N. Central Ave.</b>

**MAR 31 1970**



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance at the deceased prior to death); and (6) No physician was in regular attendance at the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
7-520 70 3368		70 3368		70 3368	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
ANNIE THOMAS				2. DATE AND HOUR OF DEATH 3.25.70 205/p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33				E. STREET AND NUMBER 415 OXFORD COURT	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	NEGRO		10-2-82	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				St. Mary's Co., Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
CARTER			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No.					Elder Lewis M. Dotson 2223 W. Hamburg St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH ADENOCARCINTMA, PANCREAS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MULT. LIVER ABCESES (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
3.20.70			YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from 3.4.70 to 3.25.1970, that (I) last saw the deceased alive on 3.25.1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE U. SYLVESTER				23B. DATE SIGNED 3.25.70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3-30-70		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 31 1970		Robert E. Dyett, M.D.		Morton & Dyett F, H, 1701 Laurens	



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BALTIMORE CITY HEALTH DEPARTMENT

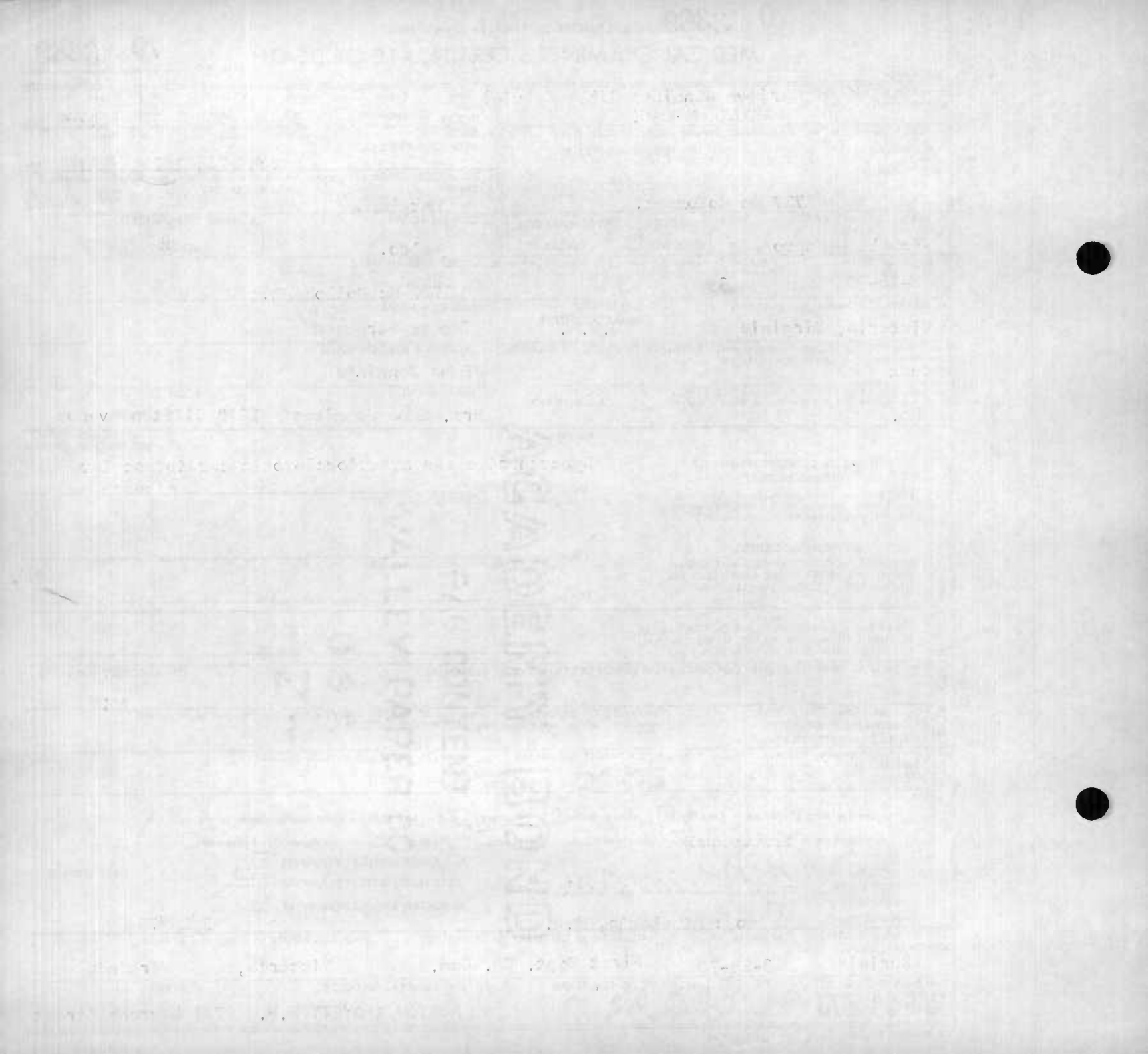
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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3369

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Marilyn Jennings Gibbs Melvin MARILYN MORGAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 24 70 11:05 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1727 Mc Colloh St.		3. DATE PRONOUNCED DEAD March 24, 1970 11:05 PM		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 14-02	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8-26-30		10. AGE (in years last birthday) 39	11. BIRTHPLACE (State or foreign country) Victoria, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Ferguson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		15. MOTHER'S MAIDEN NAME Emma Jennings	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Emma Jennings 2112 Clifton Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 3/25/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Tsidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/25/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-29-70		24C. NAME OF CEMETERY or CREMATORY First Bapt. Ch. Cem. Victoria, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-262 70 3370		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3370	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PEARL D. DECOURSEY</b>		2. DATE AND HOUR OF DEATH <b>3-24-70 5:00p. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
39		E. STREET AND NUMBER <b>207 N. Anity Apt. 11</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1887</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE - IN VALID</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>John Heath</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Heath</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No.</b>		16. SOCIAL SECURITY NO. <b>212-14 16438</b>		17. INFORMANT <b>William Decoursey</b> ADDRESS <b>207 N. Anity</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>= HYPERTENSIVE ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASES</b> <b>= CONGESTIVE HEART FAILURE</b> <b>= GENERALIZED ARTERIOSCLEROSIS</b> <b>= DEFUSED MYOCARDIAL ISCHEMIA</b> <b>= CA. OF THE COLON WITH METASTASIS</b> <b>= GALL BLADDER DISEASE</b> <b>= RHEUMATOID ARTERITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>3-24-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-4</b> 19 <b>70</b> to <b>3-24</b> 19 <b>70</b> and that (I) (we) lost saw the deceased alive on <b>3-24</b> 19 <b>70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Asuncion L. Palafox</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-24-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ASUNCION L. PALAFOX</b>		23D. ADDRESS <b>59 DUNDALK AVE, BALTO. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/28/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>MORTIMER E. DYETT, F.H.</b> ADDRESS <b>1701 LAURENCE ST.</b>	

*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

2. The second part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

3. The third part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

4. The fourth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

5. The fifth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

6. The sixth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

7. The seventh part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

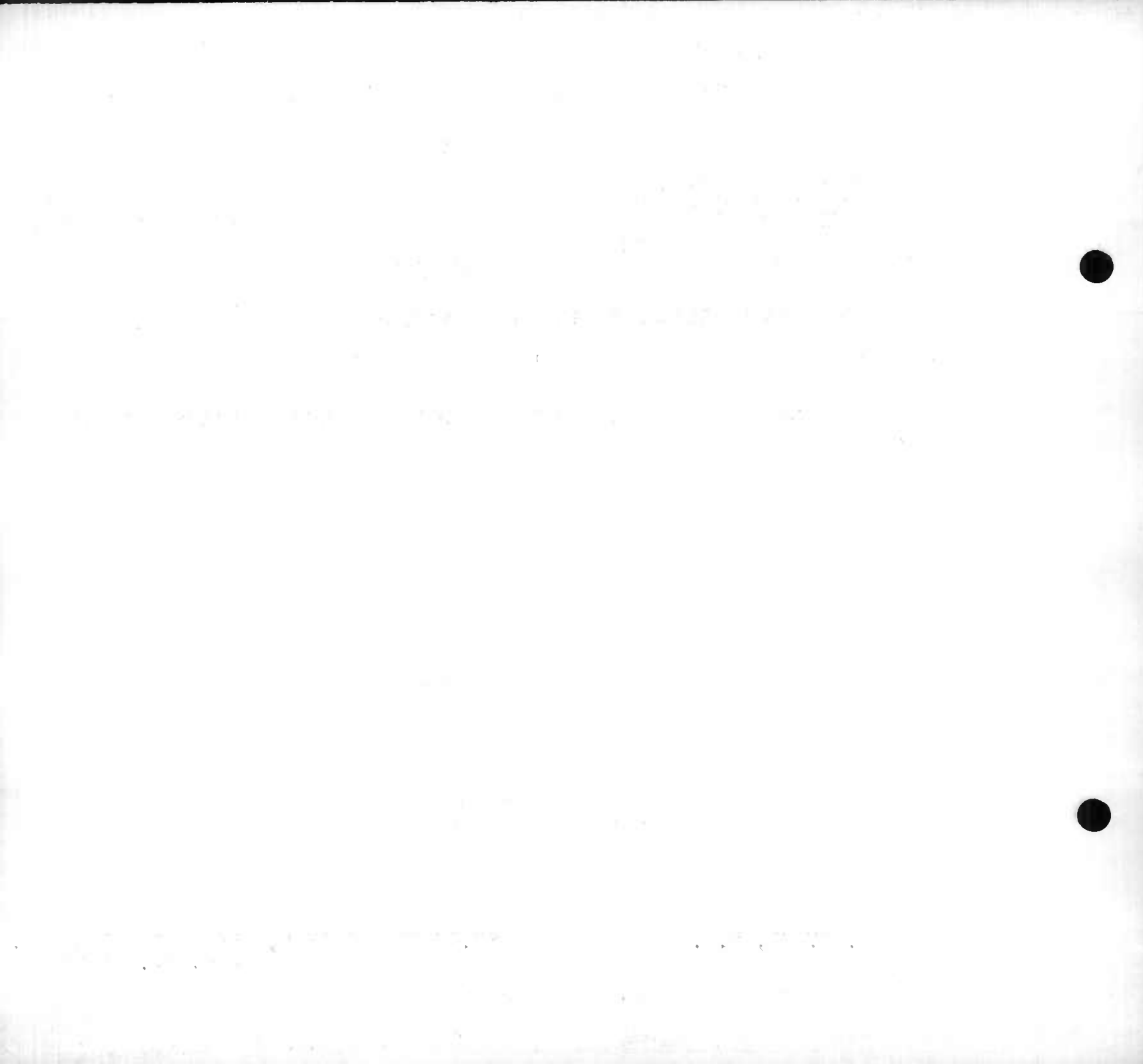
8. The eighth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

9. The ninth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

10. The tenth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 3371		CERTIFICATE OF DEATH X		REG. NO. 70 3371	
BIRTH NO. <u>M-560</u>				1. NAME OF DECEASED (Type or Print) <u>MONROE, THOMAS W.</u>			
2. DATE AND HOUR OF DEATH <u>MARCH 27, 1970</u> <u>2:25PM</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES HOSPITAL</u> <u>40 WILKENS &amp; CATON AVENUE</u> <u>BALTIMORE 21229, MD.</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>9.9.C. 52-00</u>			
				C. CITY OR TOWN <u>PASADENA</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>BOX 493, MAGOTHY BEACH ROAD</u> ZIP <u>21122</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09/02/21</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOW MOTOR OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GLIDDENS PAINT CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.A</u>	
13. FATHER'S NAME <u>WEBSTER MONROE</u> DEC'D				14. MOTHER'S MAIDEN NAME <u>BEATRICE (JOHNSON)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>220090650</u>		17. INFORMANT ADDRESS <u>BALTO. MD.</u> <u>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE</u>			
18. <u>400.3</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Malignant nephrosclerosis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial hypertrophy.</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Congestion of the lung.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 21</u> 19 <u>70</u> to <u>MARCH 27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MARCH 27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. Shams, M.D.</u> DEGREE				23B. DATE SIGNED <u>3-27-70.</u>			
23C. PHYSICIAN'S NAME (Type) <u>A. SHAMS, M.D.</u> DEGREE				23D. ADDRESS <u>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</u> <u>BALTO. MD. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-31-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON &amp; DYETT F.H. 1701 Laurens Street</u>			

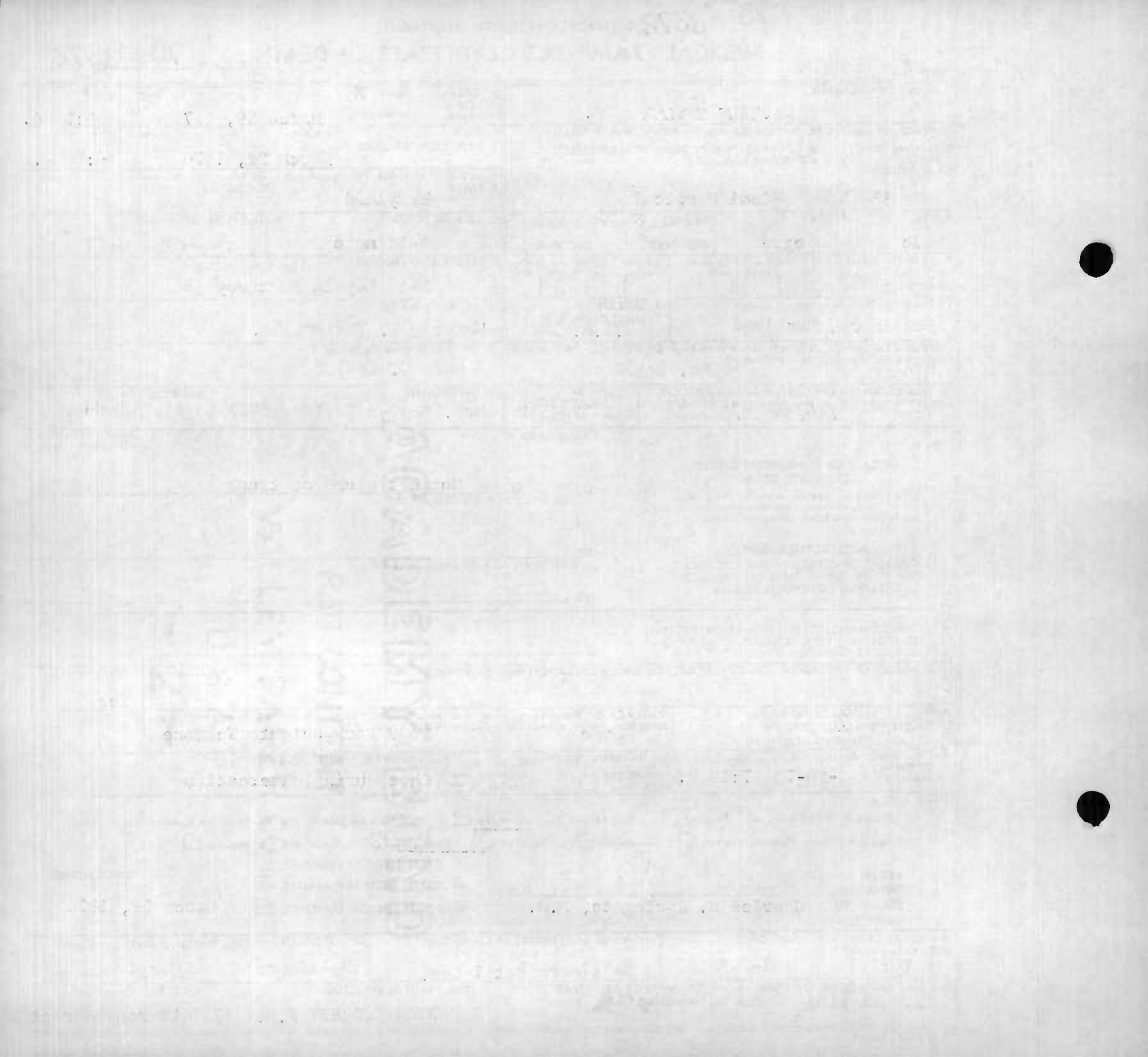


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3372

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WAVERLY TAYLOR, Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>March 29, 1970 6:00 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>422 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 29, 1970 6:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-25-1937</b>		10. AGE (in years last birthday) <b>33</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Waverly H. Taylor, Sr.</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-13</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Md. Dry Dock</b>	
15. MOTHER'S MAIDEN NAME <b>Mary C. Taylor</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9/14/54 9/30/57</b>	
17. SOCIAL SECURITY NO. <b>212-32-7512</b>		18. INFORMANT <b>Mrs. Roslyn Taylor</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E9651</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE Gunshot wound of trunk DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>3-29-70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID (if in Baltimore City, give exact location) <b>2609 Park Heights Terrace 15-13</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>3-24-70 7:10 P.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>March 29, 1970</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE RECD BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>MORTON &amp; DYETT F.H.</b>	
25C. FUNERAL DIRECTOR <b>1701 Laurens Street</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3373</u>	
G-615 70 3373 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		OSCAR T. GRIFFIN		2. DATE AND HOUR OF DEATH March 28, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-02</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1322 N. Mount Street</u>			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-17-1898			9. AGE (In years last birthday) 72		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Middlesex Co., Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Griffin		
14. MOTHER'S MAIDEN NAME Unk.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes. 9/24/18 10/3/1918		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Eunice Griffin 1332 N. Mount Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of Stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Stomach</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7-8 months</u>
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> 19 <u>44</u> to <u>3/28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>March 24</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Emerson R. Julian</u>			23B. DATE SIGNED <u>3/30/70</u>		23C. PHYSICIAN'S NAME (Type) EMERSON R. JULIAN, M. D.
23D. ADDRESS 2329 Arunah Avenue, Baltimore, Maryland			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4-1-70			24C. NAME OF CEMETERY OR CREMATOR Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens Street





# FUNERAL DIRECTOR: IMPORTANT

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J-250 70 3374		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3374	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>EARL E. JACSON</u>				2. DATE AND HOUR OF DEATH <u>3/26/70</u> <u>9:30</u> AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>48 Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>				C. CITY OR TOWN <u>SPARKS</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>Mountain Mill Road</u>			
5. SEX <u>Male</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/29/32</u>	9. AGE (In years last birthday) <u>37</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Landscaping CLUB</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas JACSON</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-30-8088</u>		17. INFORMANT <u>chart</u>		ADDRESS	
18. CAUSE OF DEATH <u>332X</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulm. embolus</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Immediate</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ILEUS</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>8 days</u>	
				(C) <u>@ vaginal hernia, &amp; herniorrhaphy</u>		<u>9 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>@ Inguinal Hernia &amp; acute infection</u>						<u>9 days</u>	
19A. DATE OF OPERATION <u>3/17/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>@ Inguinal Hernia</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Mostly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> 19 <u>70</u> to <u>3/26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donald B. Mander MD</u>				23B. DATE SIGNED <u>3/26/70</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Stenson A. H. Ch. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Sparks, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Morton + Dwyer</u>		ADDRESS <u>1701 Center ST.</u>	



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)E.  
BEATRICE HAWKINS2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3039 Harlem Ave.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

3

29

70

10:55 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

16-06

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-22-15

10. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3039 Harlem Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles Robinson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

Home

15. MOTHER'S MAIDEN NAME

Alice Robinson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL  
SECURITY NO.

218-10-2646

18. INFORMANT

Mr. James Hawkins

ADDRESS

3039 Harlem Avenue

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Metastatic carcinoma of breast  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-1-70

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 31 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens Street

ADDRESS

ALFRED B. BROWN

1900

1900

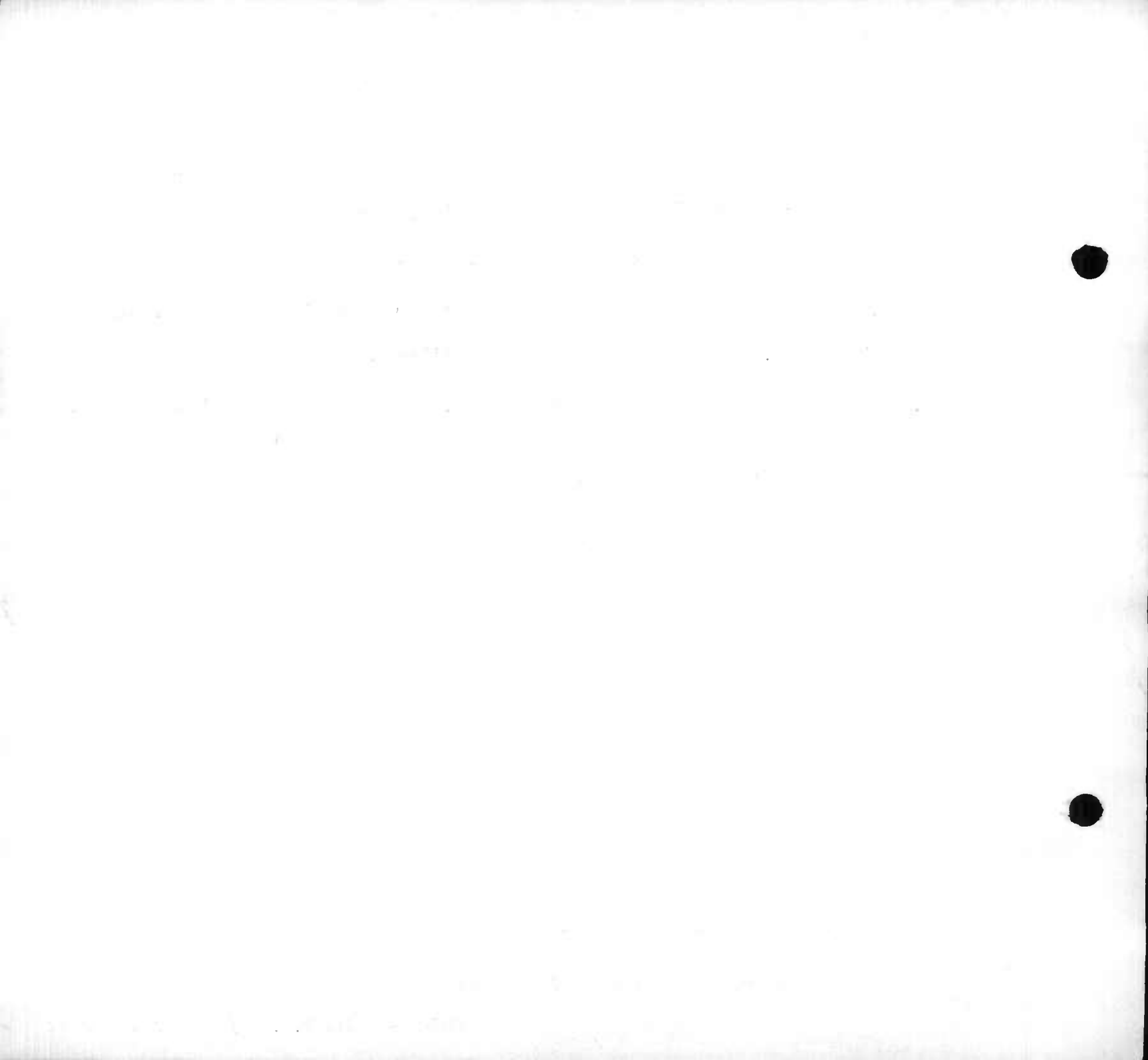
1900

*[Signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 3376</span>	
B-420 70 3376		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">RUTH MAY BALIS (Bales)</div>			2. DATE AND HOUR OF DEATH March 27, 1970 <span style="float: right;">M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">718 N. Fulton Avenue</div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">16-04</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">718 N. Fulton Avenue</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12-17-22</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">47</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Balto. City</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Hagerstown, Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">William F. Balis</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lillie C. Balis</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-22-0857</span>			17. INFORMANT <span style="font-size: 1.2em;">Mrs. Lillian Fuller</span>		
18. ADDRESS <span style="font-size: 1.2em;">3516 Woodland Ave.</span>			19. CAUSE OF DEATH <span style="font-size: 1.5em;">Acute Coronary Thrombosis</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">HYPERTENSIVE HEART DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">ARTERIOSCLEROSIS</span> (C) <span style="font-size: 1.5em;">DIABETES MELLITUS</span>		
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">10/04/50.9</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/10</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/27</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/27</span> 19 <span style="font-size: 1.2em;">70</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Gilbert L. Banfield</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">3/30/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">GILBERT L. BANFIELD</span>				23D. ADDRESS <span style="font-size: 1.5em;">722 N. Queen Ave BALTIMORE, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3-31-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mount Auburn Cemetery</span>	
		24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Maryland</span>		24E. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 31 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">MORTON &amp; DYETT F.H.</span>	
		25D. ADDRESS <span style="font-size: 1.5em;">1701 Laurens Street</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-235 70 3377</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>70 3377</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>			
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Jessie McAdams</u>		2. DATE AND HOUR OF DEATH <u>3/28/70</u> <u>11</u> <u>30</u> <u>4</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hosp.</u> <u>38</u>		C. CITY OR TOWN <u>Balto</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>626 Lafayette</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-04</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9. AGE (In years last birthday) <u>65</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Janie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mamie Ashford</u> <u>Daughter</u>
		ADDRESS <u>653 Lafayette Ave</u>	
18. <u>154.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>? Leaking Stump</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Crop Rectum</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>?</u>	
19A. DATE OF OPERATION <u>3/23/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Crop rectum</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>3/14/70</u> 19__ to <u>3/28/70</u> 19__ that (I) ( <u>we</u> ) last saw the deceased alive on <u>3/28/70</u> 19__ and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) (did) (did not) view the body after death.			
23A. SIGNATURE <u>D. Nitt &amp; Kemp</u>		23B. DATE SIGNED <u>3/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kemp</u>		23D. ADDRESS DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-2-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 31 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H.</u> ADDRESS <u>1701 Laurens</u>	

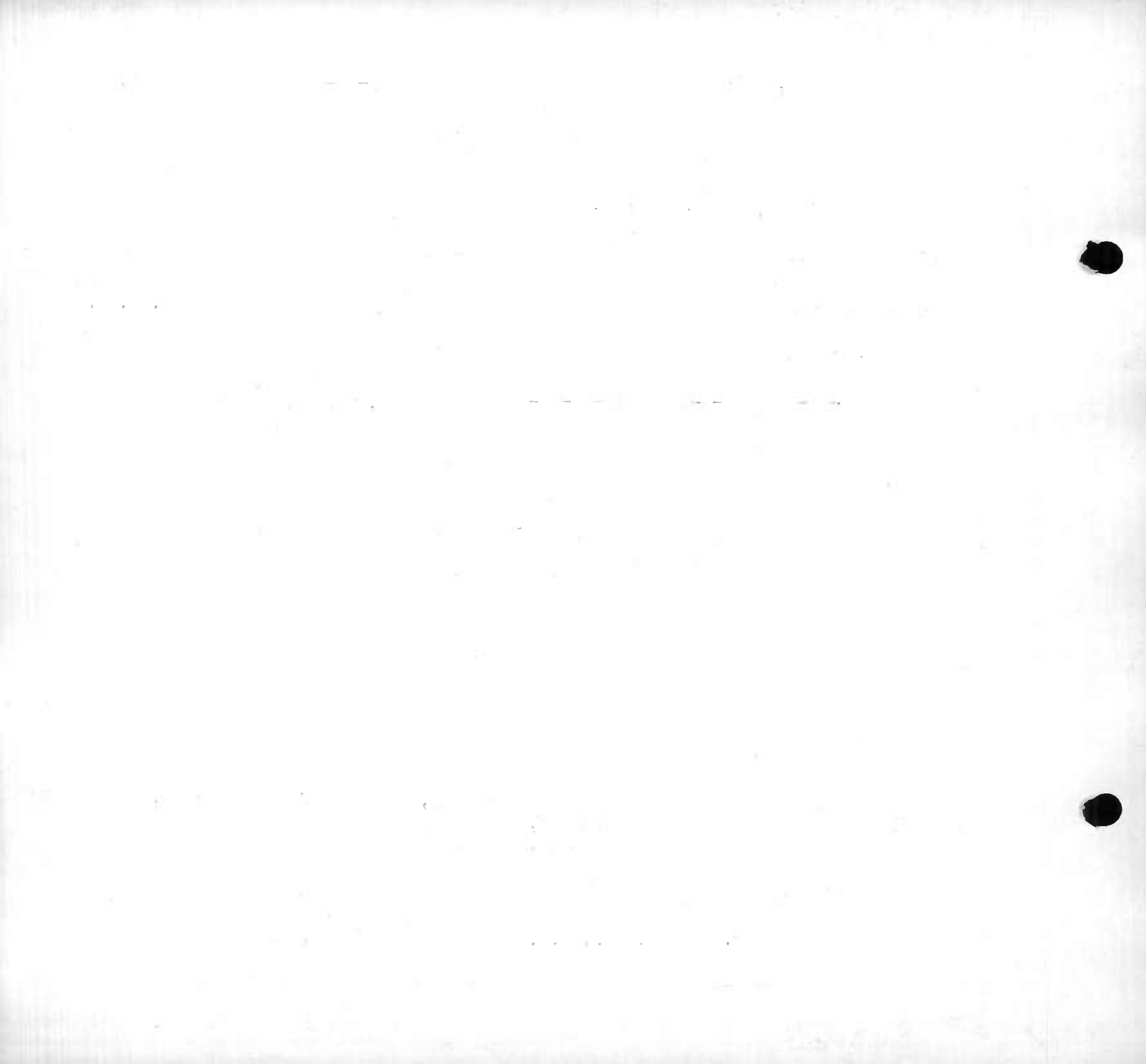




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3378</span>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>ROBINSON, Otis NMI</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>3-25-70 1:30 A.M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-04</b> <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>2229 Orem Avenue</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9- -1891</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> <b>79</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Revere Copper - Foreman</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>
<b>13. FATHER'S NAME</b> <b>Horace Robinson</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Harlett Chapman</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8-21-18 to 8-5-19</b>			<b>16. SOCIAL SECURITY NO.</b> <b>215-10-05-94A</b>		
<b>17. INFORMANT</b> <b>VA Hospital Records</b> <b>ADDRESS</b> <b>Baltimore, Maryland 21218</b>					
<b>18. CAUSE OF DEATH</b> <b>412.21</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Nephrosclerosis</b> <b>(C) Hypertensive cardiovascular disease</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Atrial Fibrillation</b> <b>Pneumonia</b>					
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>YES</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <b>XX</b> (this hospital) attended the deceased from <b>March 15, 19 70</b> to <b>March 25, 19 70</b> , that <b>XX</b> (We) last saw the deceased alive on <b>March 25, 19 70</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (not) view the body after death.					
<b>23A. SIGNATURE</b> <i>Perry G. Austin, Jr.</i>				<b>23B. DATE SIGNED</b> <b>3/25/70</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>PERRY G. AUSTIN, Jr., M.D.</b>				<b>23D. ADDRESS</b> <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>3-27-70</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Baltimore National Cemetery</b>	
		<b>24D. LOCATION</b> (City, town, or county) <b>Baltimore,</b> (State) <b>Md</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 31 1970</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Nutter Funeral Home</b> <b>ADDRESS</b> <b>3035 W. North Avenue</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3379	
L-356 3379					
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			KATNER Anna		
2. DATE AND HOUR OF DEATH			3/28/70 6:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
Lutheran Hospital of Maryland			Md.		
730 Ashburton Street			C. CITY OR TOWN		
Baltimore, Maryland 21216			BAITO.		
E. STREET AND NUMBER			D. INSIDE CITY LIMITS?		
2611 Garrison Blvd.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-16-1900	69 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		Pvt. Family		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harry Dorseý			Hattie Prettyman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-30-5256		Mrs. Lillie Turner Parkers	
				Chget Lexington Ky	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			Cerebrovascular accident		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 3-25 1970 to 3-28 1970, that (I) (we) last saw the deceased alive on 3-28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Violeta R. Gamarras M.D.			3-28-70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
VIOLETA R. GAMARRAS, M.D.			730 Ashburton St Bal. Md 21216		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	4-1-70	Daisy Cemetery	Howard Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 31 1970		Robert E. [Signature]		Nutter Funeral Home 3035 W. North Ave.	

22-10-1997

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-650 70 3380		BALTIMORE CITY HEALTH DEPARTMENT		70 3380	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>SHEARN, GEORGE EDWARD</b>			2. DATE AND HOUR OF DEATH <b>3/25/70 5:50 P</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-37</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>409 Gwynn Ave</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 8/21/20 49</b>	9. AGE (In years last birthday) <b>49</b>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Copper worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Smelting Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>George Roebuck</b>			14. MOTHER'S MAIDEN NAME <b>Annie Shearn</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1/5/43 - 6/28/46</b>		16. SOCIAL SECURITY NO. <b>212-10-5798</b>		17. INFORMANT <b>Mrs. Josephine Shearn 1327 -A. N. Fulton Ave 3800 Loch Raven Blvd., Balto., Md 21218</b>	
18. CAUSE OF DEATH <b>15-291</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Emboli</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pancreatic carcinoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Liver metastases</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>3/23/70</b> 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>common bile duct obstruction due to above</b> 20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (1) (this hospital) attended the deceased from <b>March 8th 19 70</b> to <b>March 25th 19 70</b> that (1) (we) last saw the deceased alive on <b>March 25th 19 70</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Carl E. Brubaker M.D.</b> 23B. DATE SIGNED <b>3/26/70</b> 23C. PHYSICIAN'S NAME (Type) <b>Carl E. Brubaker M.D.</b> 23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>3/30/1970</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Bush Park Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b> 25B. NAME OF REGISTRAR <b>Robert E. Nutter, M.D.</b> 25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b> ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 3381</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 1.2em;">A-430</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARIE <del>ART</del> EMMA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">March 30, 70</span> <span style="float: right;">5:25 AM</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <span style="font-size: 1.2em;">South Baltimore General Hosp.</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">21-02</span>		
5. SEX <span style="font-size: 1.2em;">F</span>			6. RACE <span style="font-size: 1.2em;">W</span>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <span style="font-size: 1.2em;">3/4/18</span>		9. AGE (in years last birthday) <span style="font-size: 1.2em;">52</span>		10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">W. Va.</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Homer Staten</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Archie Duncan</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-0-9734</span>		17. INFORMANT <span style="font-size: 1.2em;">Daughter 3822 McDo well lat #27</span>	
18. <span style="font-size: 1.2em;">153.01</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Distant Metastases</span>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Ca. Rt. Colon</span>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">II</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">March 11, 1970</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Mass abdomen</span>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 2, 1970</span> to <span style="font-size: 1.2em;">March 30</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 30</span> 19 <span style="font-size: 1.2em;">70</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Gil</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">March 30, 70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Owens Dr. Roman</span>				23D. ADDRESS <span style="font-size: 1.2em;">South Baltimore Gen. Hosp. Balto Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/2/70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Glen Haven Mem. Park</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 31 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [unclear]</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Geo. L. [unclear]</span>		25D. ADDRESS <span style="font-size: 1.2em;">2101 Frederick Ave</span>			

Death Cert. 68-11282 for husband - Jesse J.  
Ault who died Nov. 9, 1968 6-4-70 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3382				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3382	
1. NAME OF DECEASED (Type or Print) <b>STEVENSON MASON (STEVEN)</b>				2. DATE AND HOUR OF DEATH <b>3-28-70 7:29 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b>		B. COUNTY <b>20-02</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2111 W. Fayette St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-34</b>	9. AGE (In years last birthday) <b>36</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Mercy Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Buckingham, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Walter Mason, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-28-5515</b>		17. INFORMANT ADDRESS <b>Walter Mason, Jr. - 1907 W. Lafayette Ave.</b>	
18. CAUSE OF DEATH <b>5-7-8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Vertical Aneurysm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Fatty Liver</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Vertical Aneurysm</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Fatty Liver</b>				(C) <b>Acute Fatty Liver</b>		<b>days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2-2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> 19 <b>70</b> to <b>3/28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. David Nagel, M.D.</b>				23B. DATE SIGNED <b>3-28-70</b>		23C. PHYSICIAN'S NAME (Type) <b>J. DAVID NAGEL, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>R. E. Jaber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		25D. ADDRESS <b>802 Madison Avenue</b>	

Virginia

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3383		BALTIMORE CITY HEALTH DEPARTMENT		70 3383	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>RENA HANNER</b>			2. DATE AND HOUR OF DEATH <b>3/27/70 10800 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>13-03</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b>			6. RACE <b>N</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>1/8/33</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			9. AGE (In years last birthday) <b>37</b>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Jacob Sabb</b>		
14. MOTHER'S MAIDEN NAME <b>Lizzie Rouse</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Clemon Hanner</b>		
18. <b>4829 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>upper respiratory obstruction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>botanical pneumonia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>nutritional anorexia</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/28/70</b> 19 to <b>3/27/70</b> 19 that (I) (we) last saw the deceased alive on <b>3/27/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>			23B. DATE SIGNED <b>3/27/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Isaac LEVITES, M.D.</b>			23D. ADDRESS <b>SINAI HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE <b>Maryland</b>		24F. COUNTY <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>R. E. J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Lewis T. Gwynn</b>	
25D. ADDRESS <b>4517 Park Heights Ave.</b>					



FUNERAL DIRECTOR: IMPORTANT

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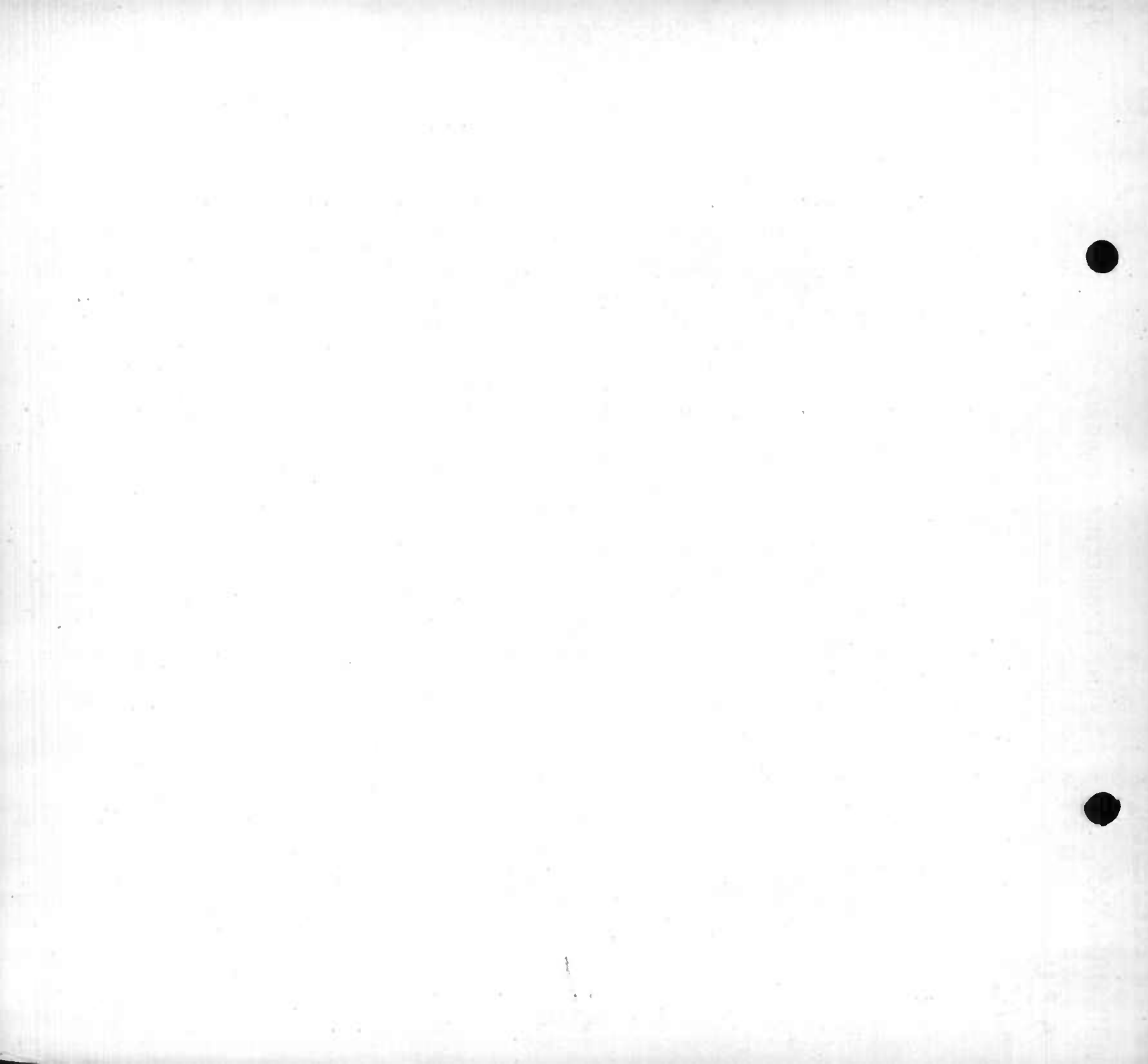
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3384	
1. NAME OF DECEASED (Type or Print) <b>Willie Hill</b>				2. DATE AND HOUR OF DEATH <b>3/25/70</b> <b>8</b> <b>P</b> <b>M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>42 Sinai Hospital of Balto.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>15-13</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital of Balto.</b>				C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2/19/92</b>		9. AGE (In years last birthday) <b>79</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tabor, North Carolina</b>	
13. FATHER'S NAME <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>223 05 3735</b>		17. INFORMANT <b>A Mrs. Irene Davis</b>	
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASCVD.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF:				(C) <b>Digitalis Toxicity.</b>			
19A. DATE OF OPERATION <b>5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> 19 <b>70</b> to <b>3/25</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos R. Perel M.D.</b>				23B. DATE SIGNED <b>3/25/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Carlos R. Perel</b>	
23D. ADDRESS <b>Sinai Hospital of Balto.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>3/31/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Lewis T. Gwynn</b>		ADDRESS <b>4517 Park Heights Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 3385		REG. NO. 70 3385	
1. NAME OF DECEASED (Type or Print) <b>MICKINS GEORGE R.</b>				2. DATE AND HOUR OF DEATH <b>3. 29. 70</b>   <b>2.00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital 130 Ashburton St; Balto.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> 21216 B. COUNTY <b>16-07</b>			
				C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2730 WINCHESTER ST.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8. 24. 05</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hecht Company</b>		11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Mickins</b>				14. MOTHER'S MAIDEN NAME <b>Emma Williams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Ser. #33725524</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Frances Mickins 2720 Winchester St.</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Terminal Carcinoma - Lung</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3. 29. 70</b> <b>3. 29. 70.</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3. 27. 1970</b> to <b>3. 29. 1970</b> , that (I) (we) last saw the deceased alive on <b>3. 28. 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>P. G. Nanes M.D.</b>				23B. DATE SIGNED <b>3. 29. 70</b>		23C. PHYSICIAN'S NAME (Type) <b>P. G. Nanes M.D.</b>	
				23D. ADDRESS <b>Lutheran Hosp. Ashburton St. Balto.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>V. Bailey Kelson F.H. 1348 Calhoun Street</b>			





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3386</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3386</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Milton Diggs</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-28-70</span> <span style="float: right;">9:55 a. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">14-03</span> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">39</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="font-size: 1.2em;">2131 Druid Hill Avenue</span>					
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2-13-99</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">71</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Unemployed</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Robt. Diggs</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lizzie</span>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes 8-3-18*5-17-19</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218098999</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Maude Diggs - wife</span>	
ADDRESS <span style="font-size: 1.2em;">Same</span>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Cerebro Vascular Accident</span>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Hypertension</span>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If yes, notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 28, 19 70</span> to <span style="font-size: 1.2em;">March 28, 19 70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 28, 19 70</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">G. Tengco M.D.</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <span style="font-size: 1.2em;">G. TENGCO M.D.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-1-70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Balto. Nat'l. Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 31 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">V. Bailey</span>	
ADDRESS <span style="font-size: 1.2em;">Kelson F.H. 1348 Calhoun Street</span>					



FUNERAL DIRECTOR: IMPORTANT

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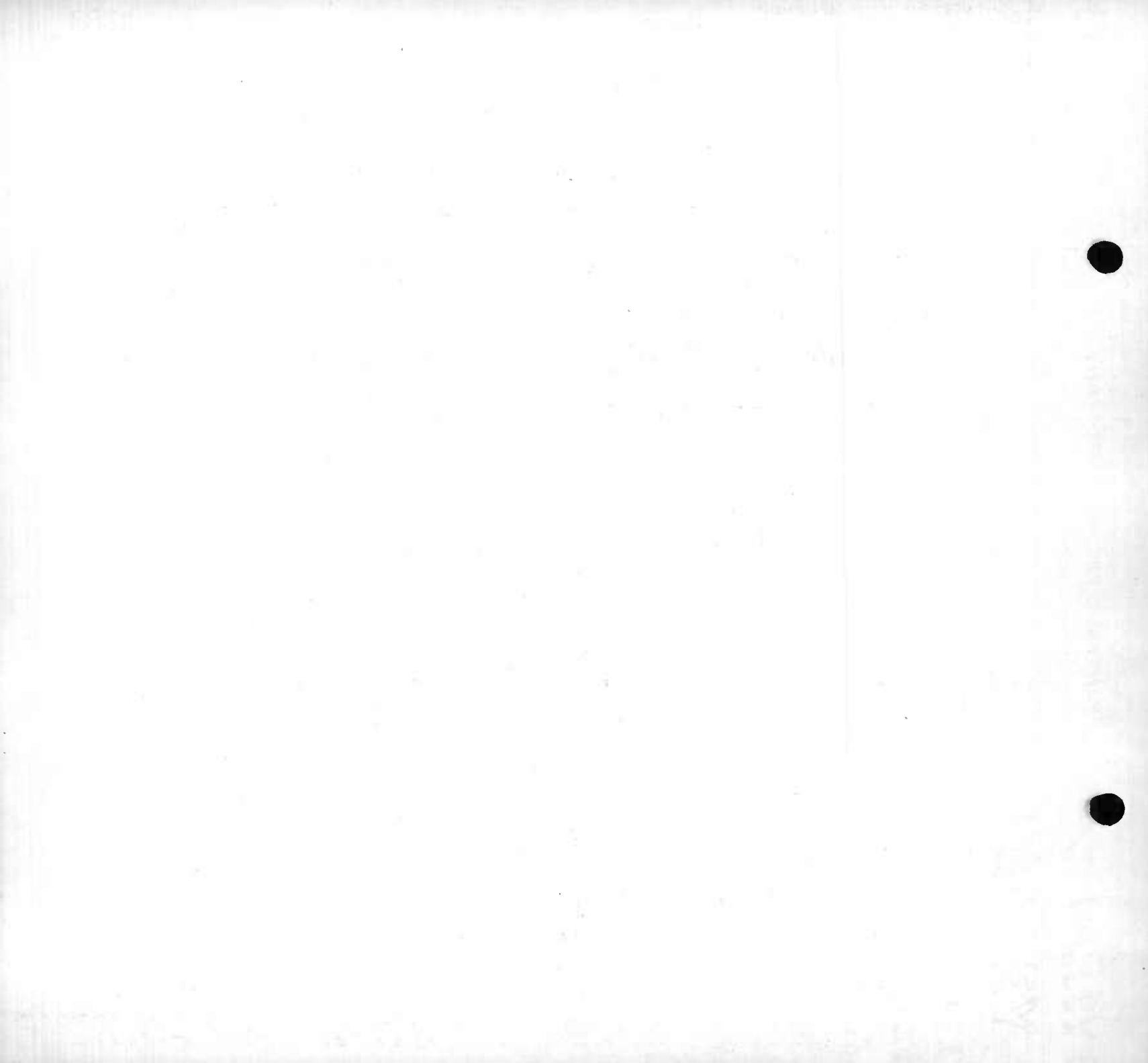
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 3387</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3387</span>		1. NAME OF DECEASED (Type or Print) <b>Captoria Hassell</b>		2. DATE AND HOUR OF DEATH <b>3-29-70 4 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 PROVIDENT HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1514 Division Street Baltimore, Maryland 21217</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Fem.</b>		6. RACE <b>Negroid</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8-12-96</b>		9. AGE (In years lost birthday) <b>73</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Hassell</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Bell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213542268</b>		17. INFORMANT <b>Mrs. Inez Reid-daughter</b>	
18. <b>4-36-01</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		<b>5 days</b> <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3. 23 1970</b> to <b>3. 29 1970</b> that (I) (we) last saw the deceased alive on <b>3. 29 19. 70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>M. J. Shapi MD</b>		23B. DATE SIGNED <b>3.29.70</b>		23C. PHYSICIAN'S NAME (Type) <b>JAVAD SHAPI MD</b>	
23D. ADDRESS <b>1514 Division Street Balto., Md.</b>		23E. FUNERAL DIRECTOR <b>Kelson F.H.</b>		23F. ADDRESS <b>1848 N. Calhoun St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. DATE RECD BY HEALTH DEPT. <b>MAR 31 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Bailey, Jr.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

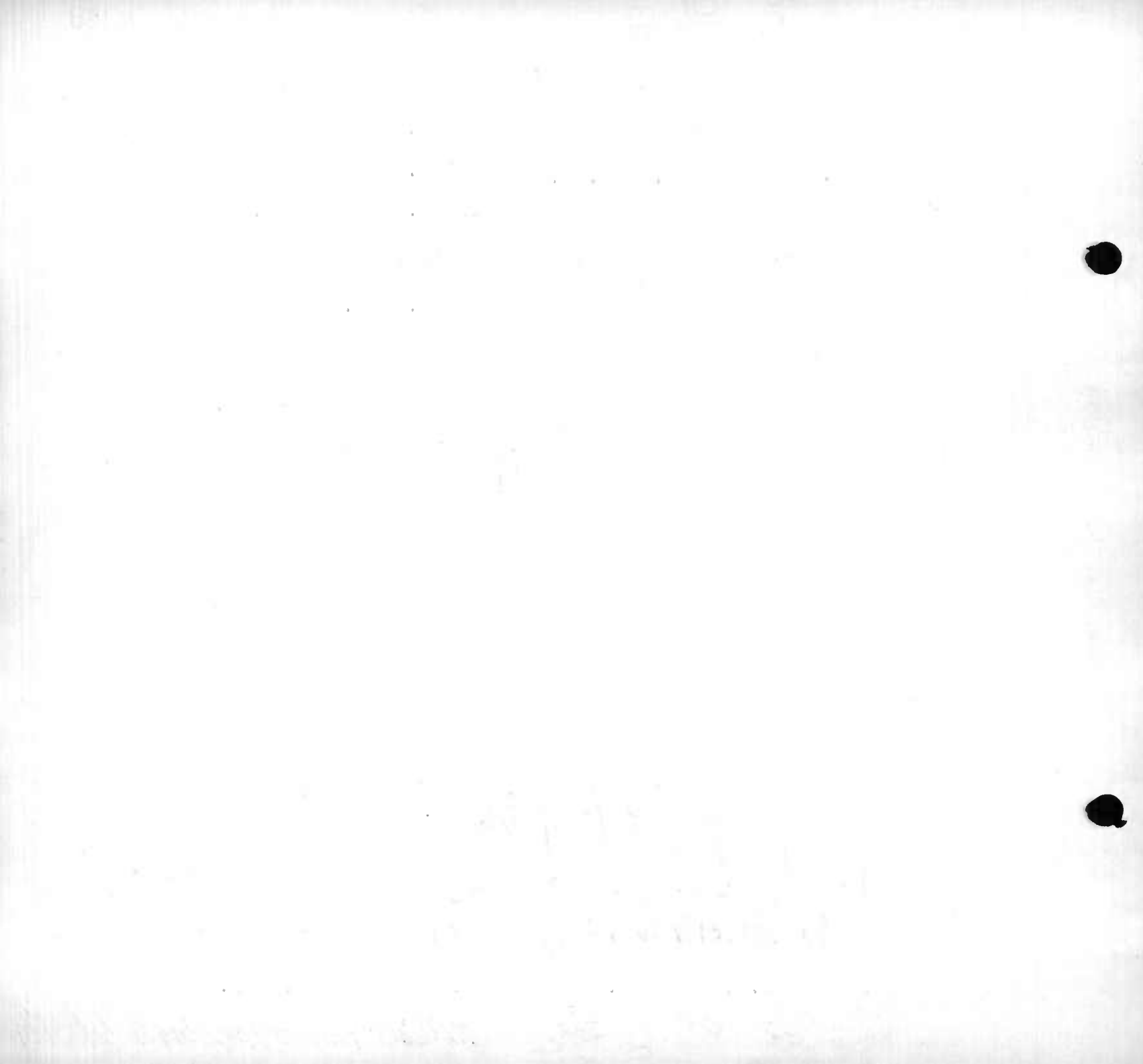
BIRTH NO.		70 3388		70 3388	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Marie Klemmick			March 28, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 1640 E. Fort Avenue Baltimore, Md.			Maryland 24-01		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			1455 Richardson St.		
8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
May 30, 1903		66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
Loan operator			Mount Vernon Hills		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U. S. A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Walter M. Wagner			Addie R. McCauley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			215-03-1416		
17. INFORMANT			ADDRESS		
Mrs. Addie R. Murdie			1640 E. Fort Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Chronic Myocardial Degeneration		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Carcinoma of Lungs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-30 1970 to 3-28 1970, that (I) (we) last saw the deceased alive on 3-28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
A.C. SOLLOD M.D.			3-30-70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
A.C. SOLLOD M.D.			707 Fort Ave. Balt. 30, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/31/70		Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
Anne Arundel, Md.		Charles L. Stevens Funeral Home, Inc.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
MAR 31 1970		B. E. Taylor, M.D.		15016 East Fort Avenue	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3389	
BIRTH NO. 70 3389		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Rachel Williams		2. DATE AND HOUR OF DEATH March 28, 1970 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 200 N. Aisquith St. Apt. 1D. 00		A. STATE Md.		B. COUNTY 5-01	
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 200 N. Aisquith St.			
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 2, 1889	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Stewart Adams		14. MOTHER'S MAIDEN NAME Mary Adams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Harry Williams 200 N. Aisquith St	
18. 41321 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Hypertensive C-V Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/25/70 to 3/28/70 and that (we) last saw the deceased alive on 3/25/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Garner		23B. DATE SIGNED 3/31/70		23C. PHYSICIAN'S NAME (Type) W. GARNER	
23D. ADDRESS 1005 W. Lafayette Ave		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE Apr. 1, 1970		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Williams Funeral Home 319 St. Schreyer	





H-620

70 3390

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3390

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR HARRIS

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

M.

March 19 1970

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3832 Greenspring Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 19, 1970

2:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

15-12

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

April 8, 1920

10. AGE (In years  
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3832 Greenspring Avenue

11. BIRTHPLACE (State or foreign country)

Ga.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CLARENCE W. HARRIS

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LONG SHOREMAN

14B. KIND OF BUSINESS OR INDUSTRY

SHIPPING

15. MOTHER'S MAIDEN NAME

OIL PAINTER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL  
SECURITY NO.

243-44560

18. INFORMANT

Pearl Harris Lee rem (4)

ADDRESS

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 19, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/23/70

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park Baltimore

24D. LOCATION (City, town, or county)

Md

25A. DATE REC'D BY HEALTH DEPT

MAR 31 1970

25B. NAME OF REGISTRAR

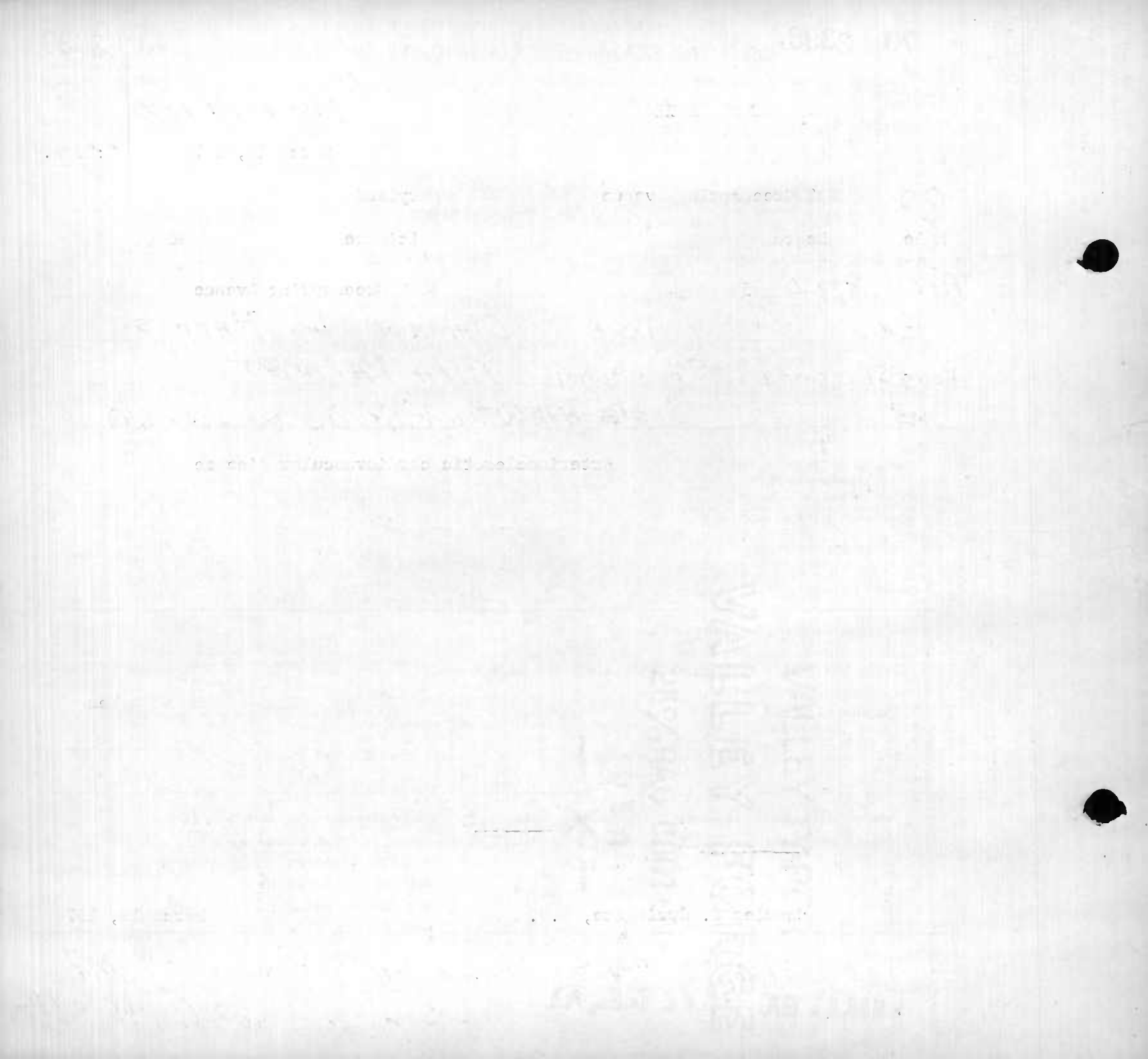
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. B. Johnson

ADDRESS

1900 Eutaw Pl. Balt. Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>11-246</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 3391</b>	
1. NAME OF DECEASED (Type as Print) <b>MCCLURE, ALBERT FRANCIS</b>			2. DATE AND HOUR OF DEATH <b>March 28, 1970 5:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4-20-70</b> <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
5. SEX <b>Male</b>			6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard Special Police</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>XXXXXX</b>		8. DATE OF BIRTH <b>5-1-04</b>
13. FATHER'S NAME <b>Nelson McClure</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Gorsuch</b>		9. AGE (In years last birthday) <b>65</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-7-42 to 3-17-43</b>			16. SOCIAL SECURITY NO. <b>218-01-3669</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
17. INFORMANT <b>Records V. A. Hospital</b> ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
18. <b>5-79-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro vascular accident</b> <b>POLYPOID TUMOR OF DUODENUM</b>			19. CAUSE OF DEATH <b>Gladys L. McClure - 5912 Franklin Avenue, Baltimore, Md. 21218</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Septic shock</b> <b>HYPERTROPHY OF LEFT VENTRICLE</b>			20. BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b> <b>2 weeks</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIVERTICULOSIS OF COLON</b>					
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>(Month) (Day) (Year) (Hour)</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 20, 1970</b> to <b>March 28, 1970</b> that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>March 28, 1970</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>HAMID M. MEHDIZADEH, MD</b>			23B. DATE SIGNED <b>3-27-70</b>		23C. PHYSICIAN'S NAME (Type) <b>HAMID M. MEHDIZADEH, MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>4-1-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taber, MD</b>		25C. FUNERAL DIRECTOR <b>Armocost Funeral Chapel-4600 Liberty Hts</b>
24D. LOCATION <b>Carroll Co, Maryland</b>			24E. LOCATION (City, town, or county) (State) <b>Carroll Co, Maryland</b>		

Letter from Veterans Adms. Hospital

4-20-70

M.H.

T-326

70 3392

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3392

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EZRA J. TEETS, JR.

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hosp. (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

A.M.

3

30

70

5:45 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md. (Arundel Gas.) Anne Arundel

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐(DIVORCED ☒

C. CITY OR TOWN

Balto. 21225

D. INSIDE CITY LIMITS?

YES ☒ NO ☐NO ☐

9. DATE OF BIRTH

23 Feb 1923

10. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

E. STREET AND NUMBER

346 Creswell Rd. 21225

11. BIRTHPLACE (State or foreign country)

Montrose, W.Va.

12. CITIZEN OF

WHAT COUNTRY?  
USA

13. FATHER'S NAME

Ezra J. Teets, Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Occasional TV Repairman TV Repairs

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cora Bell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

15 Dec 42 - 8 Oct 46

17. SOCIAL  
SECURITY NO.

18. INFORMANT (Sister) - Mrs. ADDRESS

Lillian L. Shupe - 346 Creswell Rd 21225

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Tuberculous pneumonia  
DUE TO, OR AS A CONSEQUENCE OF:(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty metamorphosis of the liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Thur. 2 April 70

24C. NAME OF CEMETERY or CREMATORY

Balto US Nat'l Cem

24D. LOCATION (City, town, or county)

Balto Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 31 1970

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Curtis E. Evans

ADDRESS

1400 S Charles St Balto Md

ACADEMIC BOARD

THE CHAIRMAN

ADVICE TO STUDENTS

RECEIVED

1964

17

1964

Occasional TV lectures

1964

William H. Miller

Miller

1964

1964

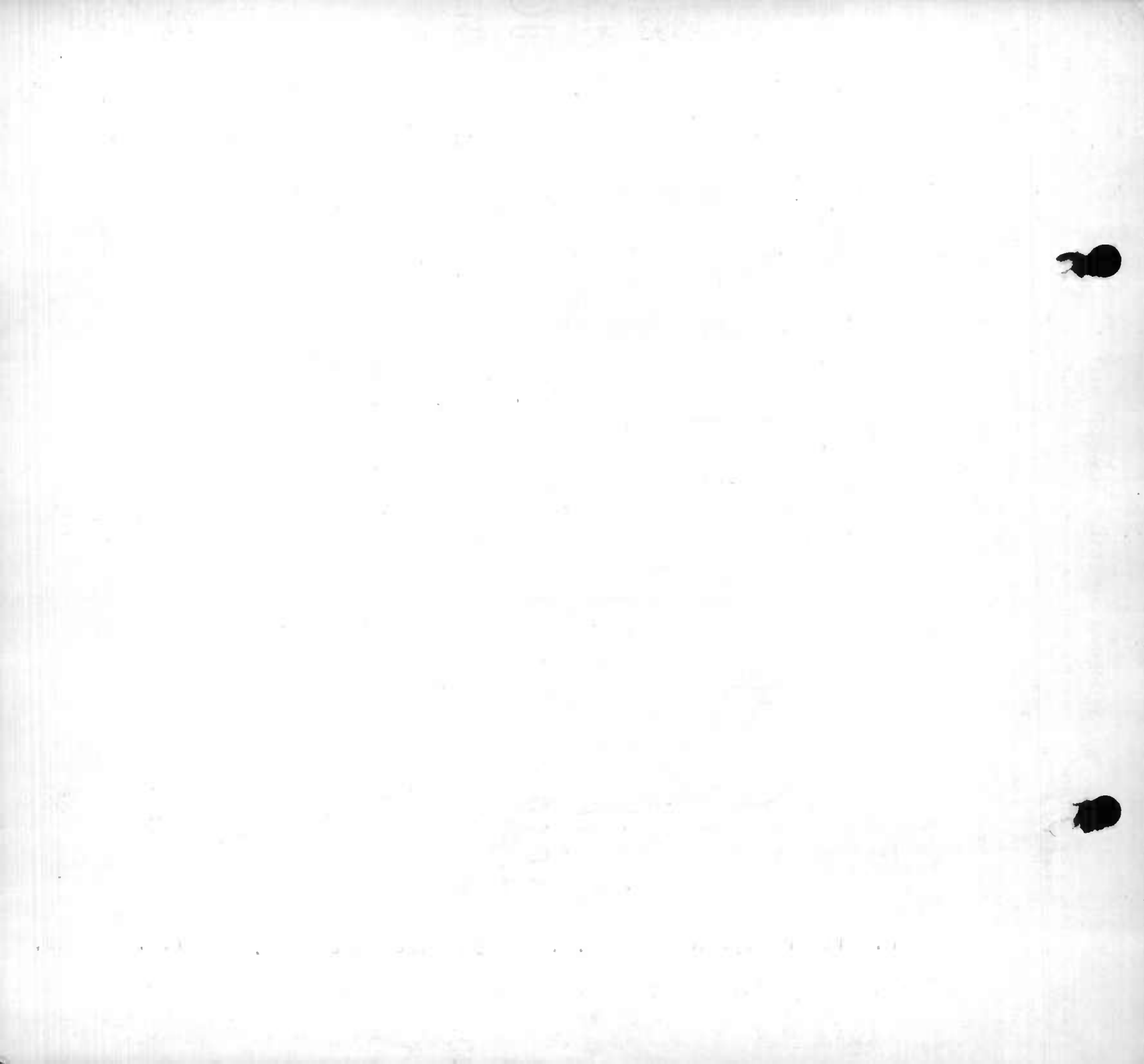
1964



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>MATTIE T. WILLIAMS</b>		2. DATE AND HOUR OF DEATH <b>3/30/70</b> <b>11:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>George Washington Nursing Home</b> <b>607 Pennsylvania Ave.</b>		A. STATE <b>md.</b>		B. COUNTY <b>7-04</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>903 Rutland Ave</b>			
5. SEX <b>male</b>	6. RACE <b>Amer. Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1894?</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Newbury, S.C.</b>	
13. FATHER'S NAME <b>Edward Williams</b>		14. MOTHER'S MAIDEN NAME <b>Julia Clark</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-22 6216</b>		17. INFORMANT <b>Chart</b>	
18. <b>4-12-31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		CAUSE OF DEATH <b>STROKE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1968</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>STROKE</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>BULLOUS PHEMPHYGOS</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>4-26-69</b> to <b>3-30-70</b> , tho (1) (we) lost saw the deceased alive on <b>3-27-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Tyson, M.D.</b>				23B. DATE SIGNED <b>3-30-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard Tyson</b>		23D. ADDRESS <b>M.D. DEGREE 936 West North Ave. Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/26/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Chesport, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Elliot Funeral Home</b>	





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

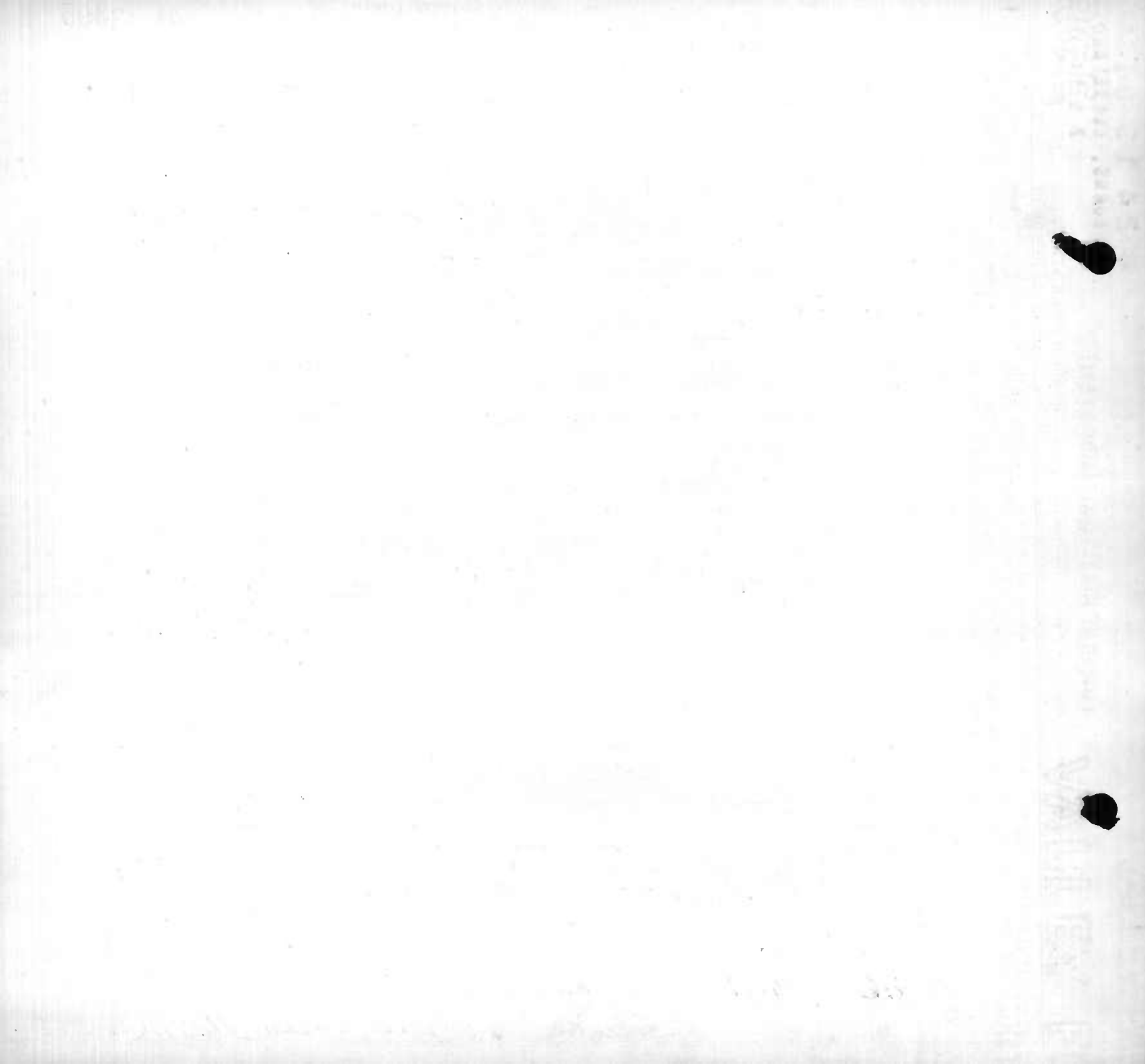
BIRTH NO. 70 3394				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3394	
1. NAME OF DECEASED (Type or Print) <b>EGGLESTON, THOMAS Hardy</b>				2. DATE AND HOUR OF DEATH <b>3-28-70 8<sup>15</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b> 4-29-70				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
5. MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>				6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 13 1943</b>				9. AGE (In years last birthday) <b>34 26</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>DAVID GEORGE EGGLESTON</b>			
14. MOTHER'S MAIDEN NAME <b>CARROLL ALBERTA GARNETTE</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Ethel Eggleston</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>E887X</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fall</b> <b>Alcoholic intoxication</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral edema</b> <b>Epidural hematoma</b> <b>Basilar skull fracture</b> <b>Fall</b> <b>Alcoholic intoxication</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 day</b> <b>1 day</b> <b>1 day</b> <b>1 day</b> <b>1 day</b>	
19A. DATE OF OPERATION <b>28 MARCH 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>EPIDURAL HEMATOMA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>IN FRONT OF 901 N. PORT ST.</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>3-27-70 7 PM</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>SUBJECT FELL ON SIDEWALK</b>		22. I certify that (I) (this hospital) attended the deceased from <b>28 MARCH 1970</b> to <b>28 MARCH 1970</b> that (I) last saw the deceased alive on <b>28 MARCH 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE <b>Karl Stecher, Jr., M.D.</b> DEGREE	
23B. DATE SIGNED <b>28 MARCH 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>KARL STECHER, JR.</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	
24B. DATE <b>4/1/70</b>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Mecherim, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Metron E. Clackson</b>		25D. ADDRESS <b>1129 N. Calhoun St.</b>		25E. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>	

Birth Cert. of Deceased from Virginia  
and V.S. 153 4-29-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3395	
BIRTH NO. 70 3395		CERTIFICATE OF DEATH		3-28-70 4.45 A.M.	
1. NAME OF DECEASED (Type or Print) CLEVELAND BORN			2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE CITY		
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7-5-14 9. AGE (In years last birthday) 55		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger			11. BIRTHPLACE (State or foreign country) North Carolina		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Leland Carter			14. MOTHER'S MAIDEN NAME Daisy Williamson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT Lillian Borne - 516 N. Chapel St.			ADDRESS		
18. 4-27-01-0119 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEVERE CONGESTIVE HEART FAILURE, COR PULMONALE, COPD, CARDIAC ARHYTHMIA, ? PULM. EMBOLISM.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). H/O TBC E OLEO - + PNEUMOTHORAX (2)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the <del>physician</del> ) attended the deceased from 3-26 1970 to 3-28 1970, that (I) <del>was</del> last saw the deceased alive on 3-28 1970 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.					
23A. SIGNATURE J. SYLVESTER			23B. DATE SIGNED 3-28-70		
23C. PHYSICIAN'S NAME (Type) J. SYLVESTER			23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION A. A. County Md.		24E. NAME OF REGISTRAR Robert E. Farber, Md.		24F. FUNERAL DIRECTOR Frank Clifton 1129 N. Caroline St.	
25A. DATE REC'D BY HEALTH DEPT. MAR 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, Md.		25C. FUNERAL DIRECTOR Frank Clifton 1129 N. Caroline St.	



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M-200

70 3396

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3396

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>OFFICER HENRY MICKEY</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>3 24 70 11:55 p.m.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> (If not in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 24, 1970 11:55 p.m.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sep 24 1941</b>				10. AGE (In years lost birthday) <b>28</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>				13. FATHER'S NAME <b>Henry Mickey</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer Balto City Police Dept.</b>	
15. MOTHER'S MAIDEN NAME <b>Dorothy Gilliam</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>E965X</b>				19. CAUSE OF DEATH <b>Gunshot wound of the heart</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				24. MEDICAL CERTIFICATION			
25. DATE OF OPERATION <b>2</b>				26. CONDITION FOR WHICH OPERATION WAS PERFORMED			
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>			
29. TIME OF INJURY (APPROX.) Month Day Year Hour <b>3 24 70 12am</b>				30. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
31. WHERE DID INJURY OCCUR? <b>Pennsylvania Ave.</b>				32. HOW DID INJURY OCCUR? <b>Officer was on duty, shot by assailant</b>			
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				34. ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihdakakis, M.D.</b>			
35. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				36. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
37. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				38. DATE SIGNED <b>3/25/70</b>			
39. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				40. DATE <b>3/30/70</b>			
41. NAME OF CEMETERY or CREMATORY <b>Balto National Cem</b>				42. LOCATION (City, town, or county) (State) <b>3501 Spadenum Ave. Md.</b>			
43. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>				44. NAME OF REGISTRAR <b>Reg. E. Faber, M.D.</b>			
45. FUNERAL DIRECTOR <b>Milton E. Elderson</b>				46. ADDRESS <b>1129 K... Rd.</b>			

1809 Penn. Ave. according to Med Exam. Office L.H. - 4-2-70



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IRENE PEARSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>March 28, 1970</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 28, 1970 6:35 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2021 Druid Hill</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-03</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2021 Druid Hill</b>	
9. DATE OF BIRTH <b>11/23/11</b>	10. AGE (In years last birthday) <b>58</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Shatter Skellie</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		15. MOTHER'S MAIDEN NAME <b>Olga Brown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>217-40290</b>		18. INFORMANT <b>Duffie Pearson</b> ADDRESS <b>2021 Druid Hill Ave.</b>	
19. <b>567.91</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Generalized peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 29, 1970</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/2/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balti. National Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Paul Chilton</b> ADDRESS <b>1129 N. Caroline St.</b>	

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**AUTOPSY GRANTED**  
**FUNERAL DIRECTOR: IMPORTANT**  
**SON, ARTIM RIES**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
CERTIFICATE OF DEATH				REG. NO.	
70 3398		70 3398		70 3398	
BIRTH NO. <b>R-200</b>					
1. NAME OF DECEASED (Type or Print) <b>Helen Ries</b>			2. DATE AND HOUR OF DEATH <b>March 19, 1970 6 pm.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>420 Bluebell Greenway</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>11 Stadel Ave.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/04</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			<b>① Ca of Breast 1962 ② Diabetes Insipidus</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 19 1970</b> to <b>March 19 1970</b> that (I) (we) last saw the deceased alive on <b>March 19 1970</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Stephen Margolis M.D.</b>			23B. DATE SIGNED <b>3/24/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>J. Stephen Margolis M.D.</b>			23D. BOARD OF MEDICAL EXAMINERS <b>ANATOMY BOARD OF MARYLAND</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3-26-70</b>		24C. NAME of CEMETERY or CREMATION <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTUARY SERVICE - BCHD</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
B-652 70 3399		La Plata, Md.		70 3399		1-25-70 110.45 P.M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Barnes Baby girl		1-25-70 110.45 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		A. STATE MD	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Indian Head		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) One		11. BIRTHPLACE (State or foreign country) John Hopkins Hospital	
13. FATHER'S NAME Raymond Barnes		14. MOTHER'S MAIDEN NAME Gloria Belfield		12. CITIZEN OF WHAT COUNTRY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Chart		18. CAUSE OF DEATH		ADDRESS John Hopkins Hospital	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. ANTECEDENT CAUSES		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE Respiratory failure			
				(B) Multiple Congenital anomalies			
				(C) Multiple Congenital anomalies			
19A. DATE OF OPERATION no operation		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
I (Month) I (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jan. 23rd 1970 to Jan. 25th 1970 that (I) (we) last saw the deceased alive on Jan. 24 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. H. A. Shukhbi				23B. DATE SIGNED 1-26-70		23C. PHYSICIAN'S NAME (Type) Saied Hassan OKBARI Shukhbi	
23D. ADDRESS ANATOMY BOARD OF MARYLAND				23E. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		23F. ADDRESS MORTUARY SERVICE - BCHD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-27-70		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 3400</u>	
C-155 70 3400				BIRTH NO. <u>70-052768</u>			
1. NAME OF DECEASED (Type or Print) <u>CHAPMAN, BABY BOY</u>				2. DATE AND HOUR OF DEATH <u>3-23-70</u> <u>4:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE In years last birthday <u>4</u>		If Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOSEPH CHAPMAN</u>				14. MOTHER'S MAIDEN NAME <u>JUNE BURKETT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>777X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Immaturity (23 weeks gestation)</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) Month: Day: Year: Hour:		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 23 1970</u> to <u>March 23 1970</u> that (I) (we) last saw the deceased alive on <u>March 23 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Johnny Eufemio</u> M.D.				23B. DATE SIGNED <u>3-23-70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>JOHNNY EUFEMIO</u> M.D.				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-27-70</u>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>APR 1 1970</u>				<u>MORTUARY SERVICE - BCHD</u>			



# FUNERAL DIRECTOR: IMPORTANT

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B-530 70 3401		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3401	
BIRTH NO. 70-03683		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baby girl Bond</i>		2. DATE AND HOUR OF DEATH <i>2-26-70 8:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>13-04</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital Belvedere Avenue Balto MD 21215</i>		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-26-70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>120 min</i>	
11. BIRTHPLACE (State or foreign country) <i>Sinai Hospital</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>Bonn Elsie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>S. H. A. Shukri Sinai Hospital</i>	
18. <i>776121</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. H. A. Shukri</i>		23B. DATE SIGNED <i>2-26-70</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b> <b>UNIVERSITY MEDICAL SCHOOL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>3-27-70</i>		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3402	
BIRTH NO. 0-416 70 3402		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) OLIVER, BABY GIRL		2. DATE AND HOUR OF DEATH 3/22/70 11 50 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital		A. STATE MD		B. COUNTY 12-04	
		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2207 N. Calvert ST.			
5. SEX F	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 22	
		11. BIRTHPLACE (State or foreign country) The Union Memorial		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ALFRED J. OLIVER		14. MOTHER'S MAIDEN NAME Williams, Fannie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 03891 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Distress		10 hours	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Sepsis?			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/22 1970 to 3/22 1970, that (I) (we) last saw the deceased alive on 3/22 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. J. J.		23B. DATE SIGNED 3/22/70		23C. PHYSICIAN'S NAME (Type) JESSE T. GATAWA, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-25-70		24C. NAME OF CEMETERY or BURIAL PLACE	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. J. J.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCDP	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 2em;">70 3403</span>	
<b>B-240 70 3403</b> BIRTH NO. <u>70-02904</u>		1. NAME OF DECEASED (Type or Print) <u>BOSLEY ANNA MARIE</u>				2. DATE AND HOUR OF DEATH <u>24 MARCH 1970</u> <u>6<sup>10</sup> A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>Union Memorial Hospital</u> <u>44</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Hawthorne Co.</u> C. CITY OR TOWN <u>Box 252 Baltimore City</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Box 252 Johnson Mill Rd.</u>			
5. SEX <u>female</u>		6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-17-70</u>	
9. AGE (In years last birthday) <u>27</u>		10. KIND OF BUSINESS OR INDUSTRY <u>U.S.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Juanita Bosley</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <u>079.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cytomegalic inclusion disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION <u>2</u>				20. AUTOPSY? (Yes or No) <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <u>17 FEBRUARY</u> 19 <u>70</u> to <u>24 MARCH</u> 19 <u>70</u> that <del>(it)</del> (we) lost the deceased alive on <u>24 MARCH</u> 19 <u>70</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <u>John P. Pacanowski, M.D.</u> DEGREE				23B. DATE SIGNED <u>24 MARCH 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN P. PACANOWSKI, M.D.</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-25-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMIC BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or county) / (State) <u>BALTO, MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MONTUARY SERVICE - BCND</u>			

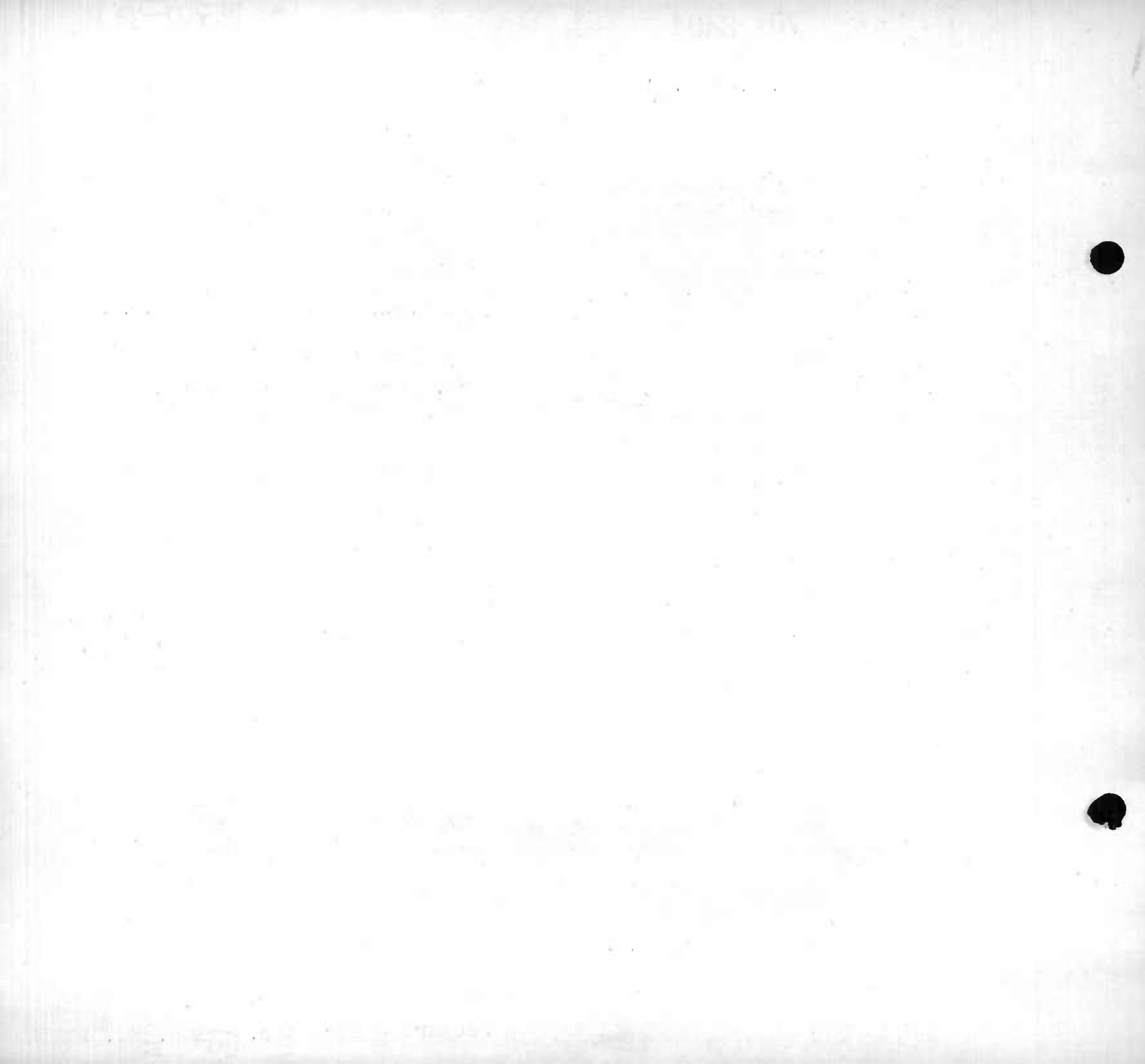
4. 2009. 10. 15. 목요일

## 6. Summary

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3404</span>	
L-320 70 3404				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Ludwig, Mrs. Pearl L.</b>			2. DATE AND HOUR OF DEATH <b>3/30/70</b>   <b>8:45</b> a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Keswick Home for Incurables</b> <b>700 West 40th Street, Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Lutherville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1805 Charmuth Garth</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1892</b>	9. AGE (In years last birthday) <b>77 years</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Charles Clarke</b>			14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Jewel</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-24-8217</b>		17. INFORMANT <b>Mrs. Mary Lee Corke---Same &amp; Keswick Records</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>450X I</b> <b>Multiple pulmonary embolus</b> <b>U.K.S.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASCVD @ homeoplax</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Jan 11 1968</b> to <b>Mar 30 1970</b> , that (1) we last saw the deceased alive on <b>Mar 30 1970</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) We (did) (did not) view the body after death.					
23A. SIGNATURE <b>RK Gundry</b>				23B. DATE SIGNED <b>3-31-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard K/ Gundry, M.D.</b>				23D. ADDRESS <b>700 W. 40th Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>		24F. ADDRESS <b>Balto. Md. 21214</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>K-523</span> <span>70 3405</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="text-align: center;"> <span style="font-size: 24pt;">70 3405</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>70 3405</span> </div>	
BIRTH NO. <span style="font-size: 24pt;">K-523</span>		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type in Print) <b>MAUDE EVELYN KNIGHTON</b>		2. DATE AND HOUR OF DEATH <b>3/30/70 9:35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>GOULD CONVALESCARIUM</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-59</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1522 KINGSWAY RD.</b>	
5. SEX <b>F</b>	6. RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG-13-1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William L Sappington</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Simpson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-9163</b>	
17. INFORMANT <b>Mr William S Knighton</b>		ADDRESS <b>Same</b>	
18. <b>4/2/70 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1. Arteriosclerotic Heart Disease</b> <b>2. Generalized arteriosclerosis</b> <b>3. (B) Bacterial pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(C) Terminal</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Chronic Bladder Disease agitated Disturbance Symptomatic depression</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1 1960</b> to <b>Mar. 30 1970</b> , that (I) <del>we</del> last saw the deceased alive on <b>Mar 29 1970</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.			
23A. SIGNATURE <b>Donald W. Montze</b>		23B. DATE SIGNED <b>Mar 30 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald W. Montze</b>		23D. ADDRESS <b>3009 EVERGREEN AVE BALD MD 21214</b>	
24A. BURIAL CREMATION; REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/2/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruick Inc. Baltimore, Maryland</b>		ADDRESS	

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3406	
1. NAME OF DECEASED (Type or Print) JULIUS W. WEST SR.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 39 E. Hamburg St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 30 70 7 A. M.			
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 23-02			
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH July 25, 1917		10. AGE (In years last birthday) 52		E. STREET AND NUMBER 39 E. Hamburg St.			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Julius R. West			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		14B. KIND OF BUSINESS OR INDUSTRY Ship Yard		15. MOTHER'S MAIDEN NAME Eva M. Harris			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Julius W. West Jr. 1713 William St.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R. Fisher</i> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-30-70 EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 3 70		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mc Cully 130 E. Fort Ave			

ACADEMIC PROMISE

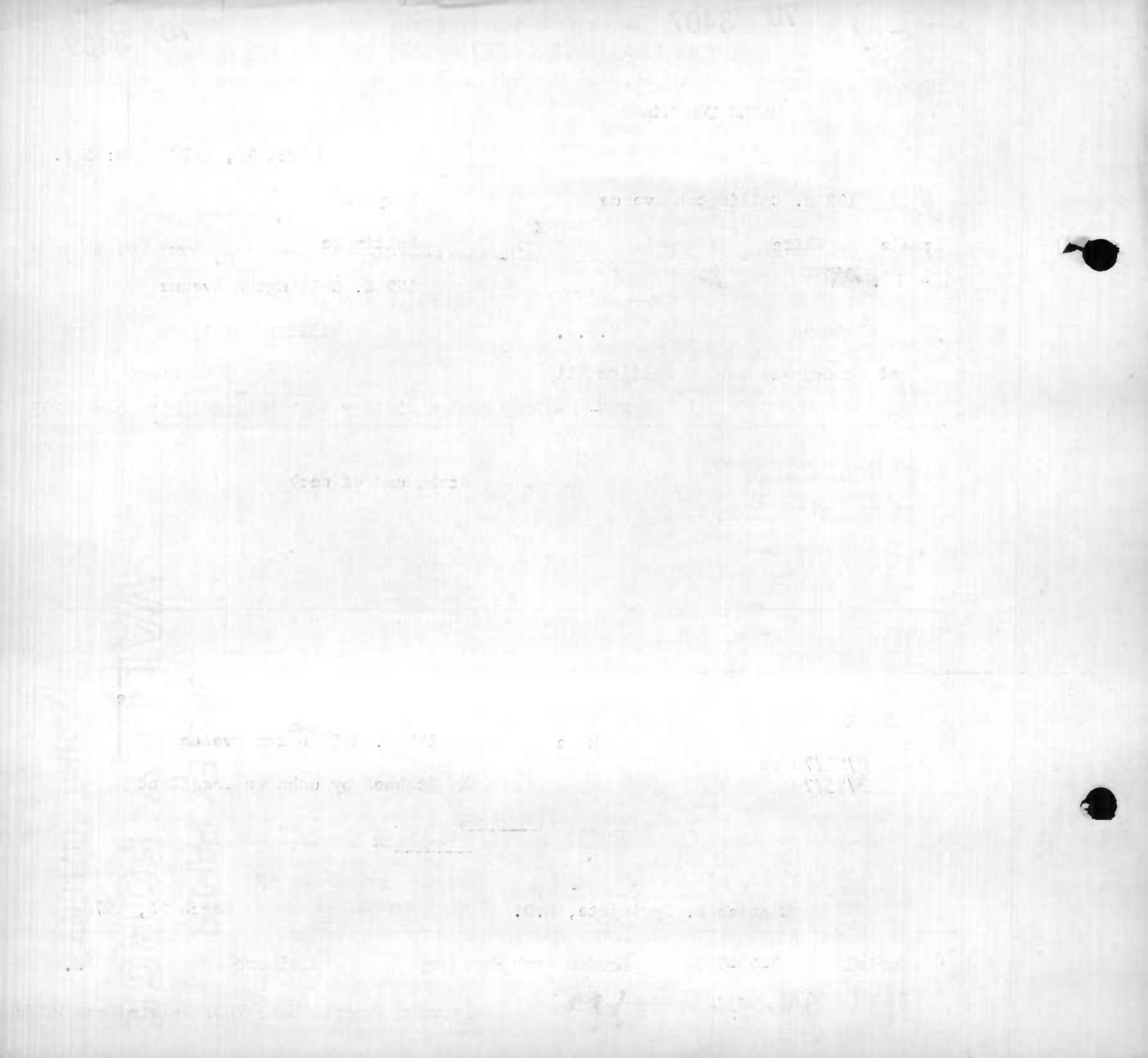
THE CONTENT

VALLEY CAPITAL CO

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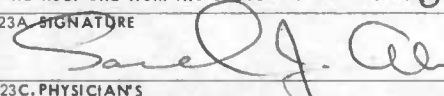
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1		70 3407		BALTIMORE CITY HEALTH DEPARTMENT		70 3407	
T-514				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MABLE TUMBLESON</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 122 S. Collington Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year <b>March 25, 1970</b>		Hour <b>9:35 P. M.</b>	
6. SEX <b>Female</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-28-1879</b>				10. AGE (In years last birthday) <b>90</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William Tumbleson</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-05</b>	
15. MOTHER'S MAIDEN NAME <b>Odonahoo</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>220-44-8768</b>	
18. INFORMANT <b>Evelyn Kistner 8067 Philadelphia Road 21237</b>				19. CAUSE OF DEATH <b>E966X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Stabwound of neck</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>122 S. Collington Avenue</b>	
22D. TIME OF INJURY (APPROX.) <b>3/24/70 8r</b> <b>3/25/70 ?</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed by unknown assailant</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 26, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-28-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Gentry</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road 21236</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3408</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-520 70 3408</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>Madelyn Swank</b>		<b>3/31/70</b>		<b>12:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
<b>7128 McClean Blvd.</b>			<b>Maryland</b>		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			<b>Baltimore</b>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			<b>7128 McClean Blvd.</b>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
<b>Female</b>	<b>White</b>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>5/19/1928</b>	<b>41</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Clerk</b>		<b>Retail Store</b>		<b>Maryland</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>Russell Thornton</b>			<b>Laura Turner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>No</b>		<b>218-12-7884</b>		<b>John Swank - 7128 McClean Blvd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
<b>ANTECEDENT CAUSES</b>			<b>Respiratory arrest.</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			<b>Carcinoma of both breasts with metastasis to spine, ribs etc.</b>		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>2/11/70</b>		<b>Carcinoma left breast</b>		<b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from <b>2/7/1968</b> to <b>3/31/1970</b> , that (1) (we) lost saw the deceased alive on <b>3/2/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				<b>3/31/70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<b>Samuel J. Abrams, M.D.</b>				<b>7220 Park Heights Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>4/3/70</b>		<b>Cem. St. John*s Lutheran Ch.</b>	
				24D. LOCATION (City, town, or county) (State)	
				<b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH. DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>APR 1 1970</b>		<b>Robert C. Altenburg</b>		<b>Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214</b>	

1935-1936

1937-1938

1939-1940

1941-1942

1943-1944

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em; float: left;">G-632</span>				70 3409		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 2em; float: left;">70 3409</span>	
1. NAME OF DECEASED (Type or Print) <b>Katherine M. Greutzner</b>						2. DATE AND HOUR OF DEATH <b>March 29, 1970 2:15 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Key Circle Hospice 1214 Eutaw Pl. Balto., Md.</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN <b>Balto. 21234</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1263 Deanwood Rd. Balto. Md. 21234</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1884 85</b>		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl Fritze</b>						14. MOTHER'S MAIDEN NAME <b>Wilhelmina</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213 18 6323</b>		17. INFORMANT <b>Wm. P. Greutzner</b> ADDRESS <b>1263 Deanwood Rd.</b>					
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ACVD.</b>						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Old age</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.						(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Old age</b>					
(C) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years ago</b>					
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>3-11-70</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>3-11-70</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-11-70</b> to <b>3-28-70</b> and that (I) (we) last saw the deceased alive on <b>3-28-70</b> and that in (my) (our) opinion death occurred on the date <b>3-28-70</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Alfred Wiedmann</b>						23B. DATE SIGNED <b>3-30-70</b>				23C. PHYSICIAN'S NAME (Type) <b>ALFRED WIEDMANN</b>	
23D. ADDRESS <b>715 PARK AVE, BALTO, MD.</b>				23E. DEGREE		23F. DEGREE		23G. DEGREE		23H. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>4/1/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>				25B. NAME OF REGISTRAR <b>John E. Johnson</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Wm. E. Johnson 8521 Loch Raven Bldg</b>			



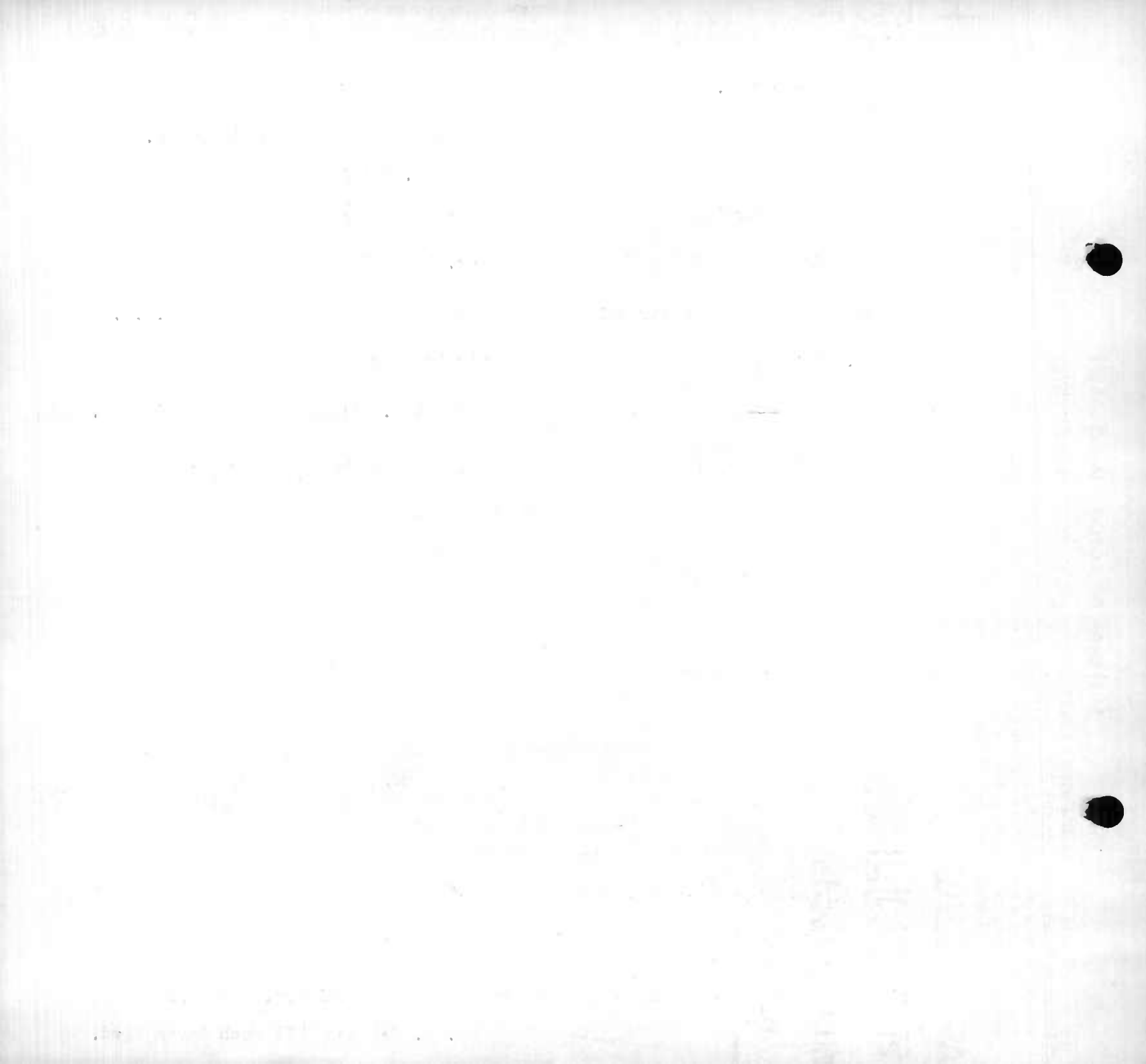




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

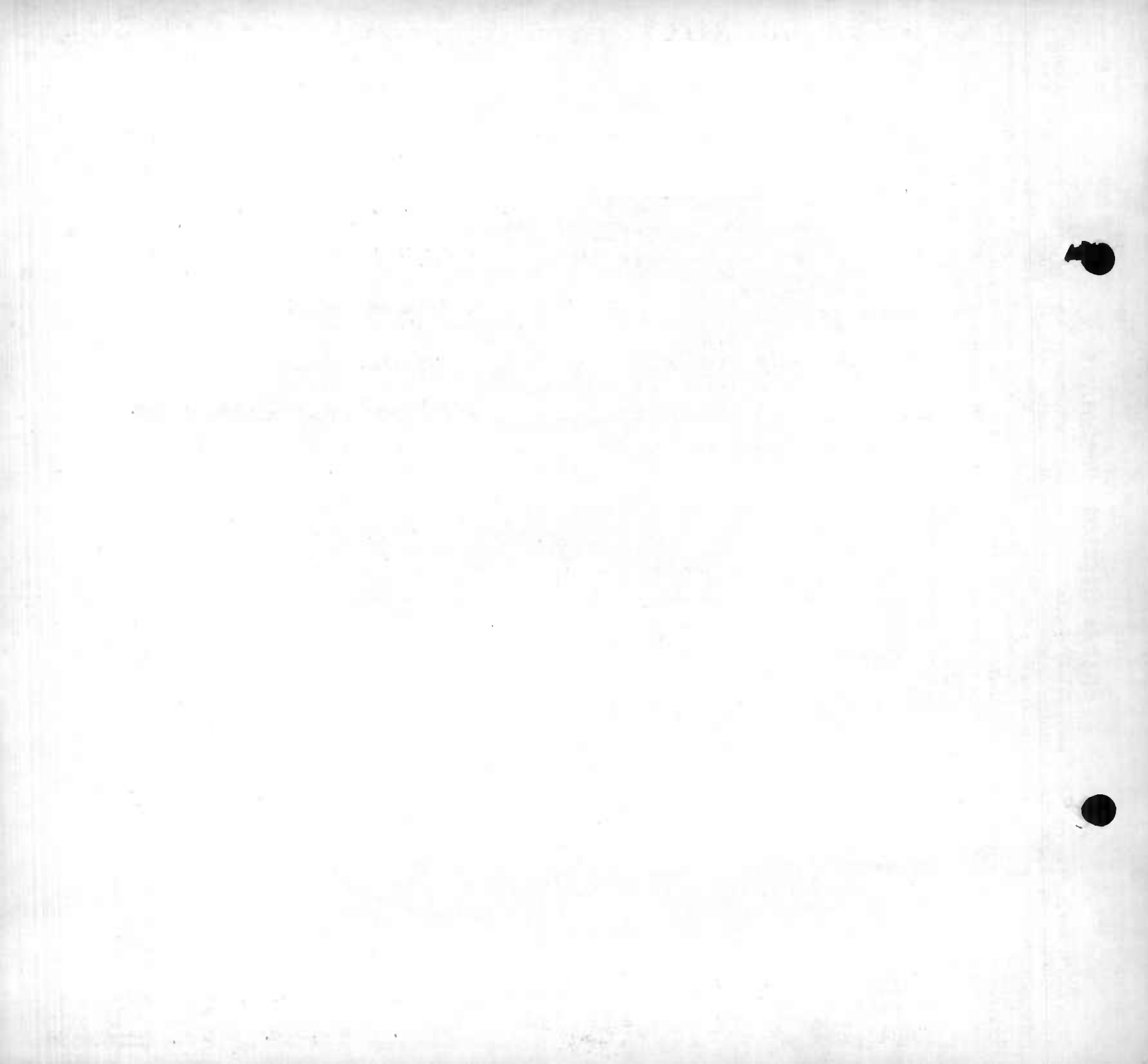
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3410</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">V-262 70 3410</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">WILLIAM A. VICKERS</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">March 27, 1970</span> <span style="float: right;">6:30 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">90 Edgewood Nursing Home</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore Co.</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Balto. 21212</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">6684 Loch Hill Road</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Carpenter</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Construction</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Oct. 20, 1898</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William W. Vickers</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Minnie Puls</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">71</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215 05 3378A</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Clement J. Vickers</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">6684 Loch Hill Rd. 212</span>	
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Carcinoma of Lung c Metastatic</span> </div> <div style="width: 45%;"> <b>(B)</b>                      DUE TO, OR AS A CONSEQUENCE OF:                 </div> <div style="width: 50%;"> <b>(C)</b> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">June 6, 1970</span> <b>to</b> <span style="font-size: 1.2em;">March 27, 1970</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">March 26, 1970</span> <b>and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Jamshid Hamed MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/27/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">JAMSHID HAMED MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">TOWSON 9, MD</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3/30/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Most Holy Redeemer</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">APR 1 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">John E. Taylor MD</span>			
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Wm. E. Johnson</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">8521 Loch Raven Blvd.</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3411</b>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Katherine Stumpf</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>March 28, '70</i>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Hartford Gardens Nursing Home</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>6-02</i> <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <i>213 N. Lakewood Ave.</i>			
<b>5. SEX</b> <i>F</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>12/16/'77</i>	<b>9. AGE</b> (In years lost birthday) <i>92</i>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Baltimore, Maryland</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		<b>13. FATHER'S NAME</b> <i>Marcellus Stiefenhofer</i>			
<b>14. MOTHER'S MAIDEN NAME</b> <i>Unknown</i>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <i>Joseph Stumpf</i> <b>ADDRESS</b> <i>3626 Elmore Ave.</i>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the immediate cause of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C) Uremia</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>Years</i>	
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <i>0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <i>No</i>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)	
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from <i>Nov 1969</i> to <i>March 1970</i>, that (I) <i>we</i> last saw the deceased alive on <i>3/27</i> 19 <i>70</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>James J. McPhillips</i>				<b>23B. DATE SIGNED</b> <i>3/30/70</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>JAMES J. McPHILLIPS MD</i>				<b>23D. ADDRESS</b> <i>2 E Read St Balto 21202</i>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>3/31/'70</i>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Holy Redeemer Cemetery</i>	
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Maryland</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>APR 1 1970</i>			
<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor, M.D.</i>		<b>25C. FUNERAL DIRECTOR</b> <i>John A. Moran, Inc.</i> <b>ADDRESS</b> <i>3000 E. Baltimore</i>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John M. Robinson

2. DATE AND HOUR OF DEATH

3/27/70

3:00

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

10 S. Conkling Street

21224

007

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7-14-07

9. AGE (In years  
last birthday)

62

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)Chauffeur W. Va. Ret. Disability  
rape and pulp Co

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Robinson

14. MOTHER'S MAIDEN NAME

Sophie Rupert

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-07-3922

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18.

162, 1

CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

pneumonia

2 wks.

(B) metastatic bronchogenic carcinoma

8 months

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notly medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/27 1970 to 3/27 1970,  
that (I) (we) last saw the deceased alive on 3/27 1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

J.R. Neefe

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3/27/70

23C. PHYSICIAN'S  
NAME (Type)

J.R. Neefe

23D. ADDRESS

BCH-

4940 Eastern Avenue  
Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/31/70

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 1 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

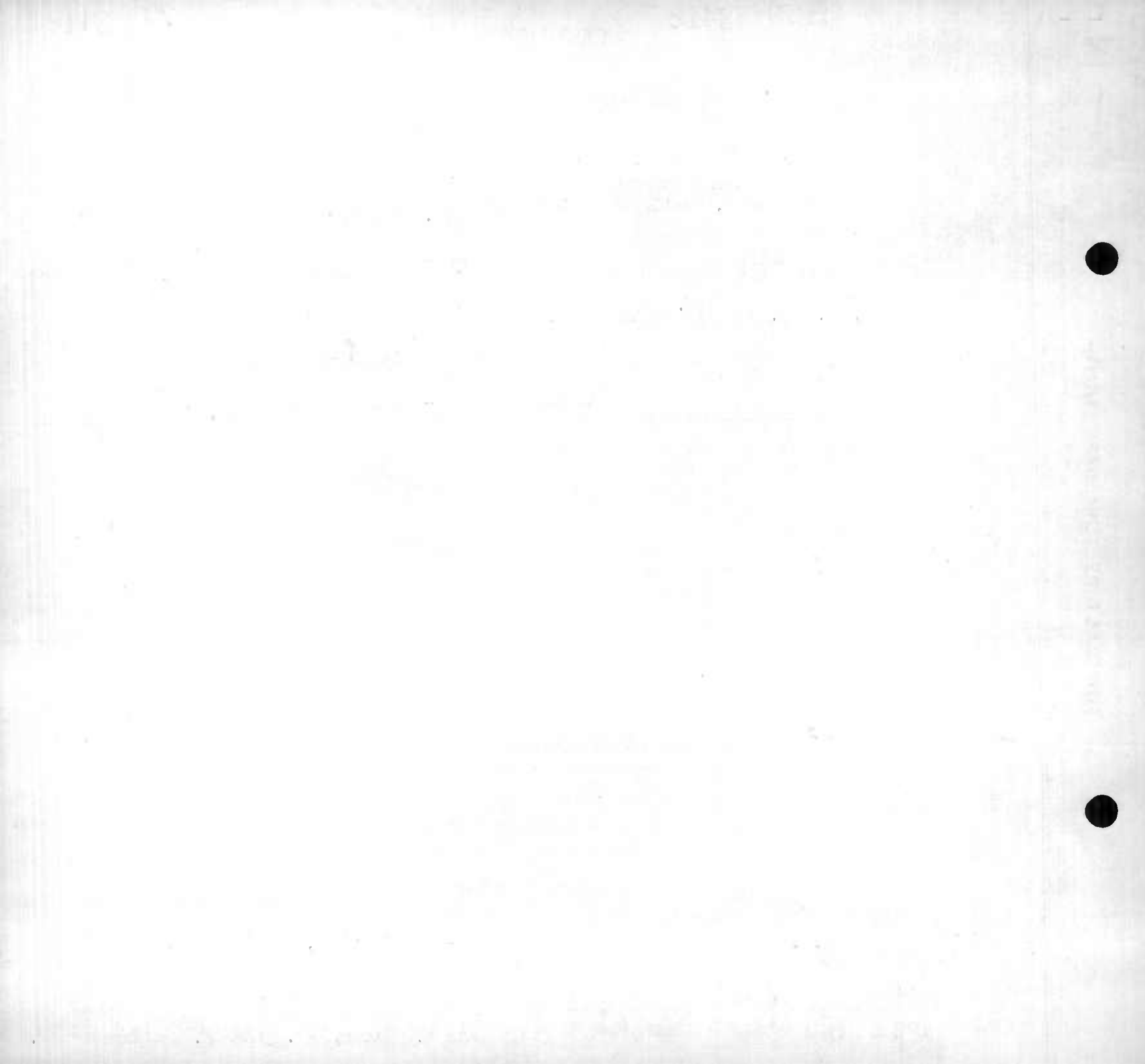
25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-162 70 3413				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3413	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>ANNA EPPERSON</u>			
2. DATE AND HOUR OF DEATH <u>3-26-70</u> <u>10:00 P. M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>6-01</u>				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home &amp; Hospital</u>			
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>144 D. Cunley St.</u>		6. SEX <u>F</u>	
7. RACE <u>W</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>10-28-09</u>		10. AGE (In years last birthday) <u>60</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas White</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Eder</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-20-7097</u>		17. INFORMANT <u>Leroy Epperson</u>		ADDRESS <u>145 N. Steeper St. 2x</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE SEVERE PULMONARY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>EDEMA</u> (B) <u>? MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>AURICULAR FIBRILLATION</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>3-26-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> 19 <u>70</u> to <u>3-26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3-26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>				23B. DATE SIGNED <u>3-26-70</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>	
23D. ADDRESS <u>Church Home &amp; Hosp. (Balt., Md. 21231)</u>				23E. DEGREE <u>DEGREE</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/30/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Balto. St.</u>			

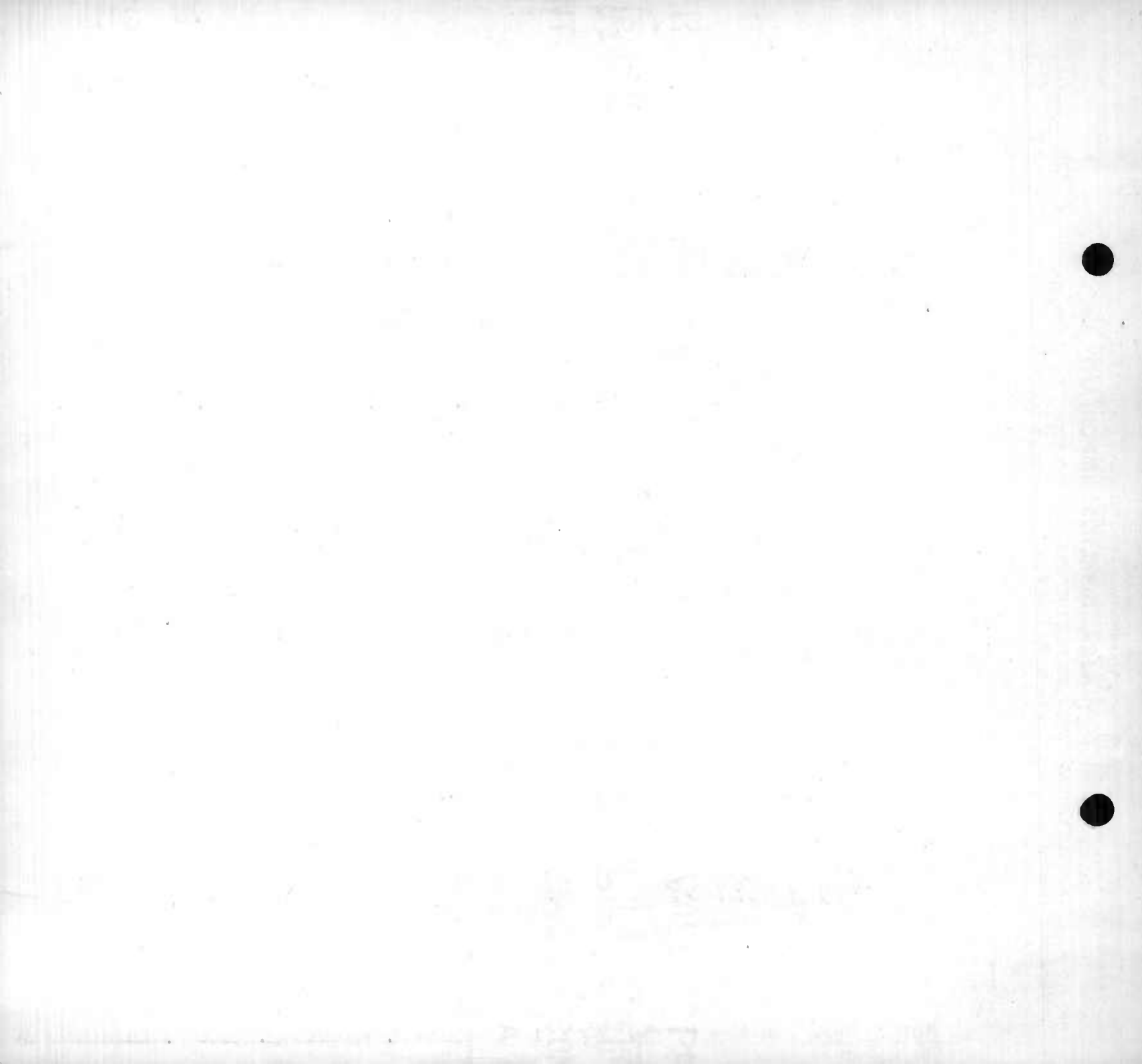




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3414</span>	
C-600 <span style="font-size: 1.5em;">70 3414</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARGARET CARR</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/28/70</span> <span style="font-size: 1.5em;">8<sup>30</sup></span> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <span style="font-size: 1.5em;">33 JOHNS HOPKINS HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">33 JOHNS HOPKINS HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">218 E. PRESTON STREET</span> <span style="font-size: 1.2em;">11-01</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/13/05</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">64</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Registered nurse</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Ireland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">Not in U SA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Costella</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">579-74-4525</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Francis X Carr 218 E. Preston St.</span>	
18. <span style="font-size: 1.2em;">571.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">LAENNEC'S CIRRHOSIS</span>  (B) <span style="font-size: 1.2em;">CHRONIC ALCOHOLISM</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;">2 yrs</span>  <span style="font-size: 1.2em;">10 yrs</span>  <span style="font-size: 1.2em;">1 WEEK</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">GRAM NEGATIVE SEPSIS - RESOLVING</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/24</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Karl J. Kramer</span>		DEGREE <span style="font-size: 1.2em;">KARL J. KRAMER</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">3/28/70</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/31/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">New Cathedral Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 1 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">John A. Moran, Inc.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">3000 E. Baltimore St.</span>			



Z-100

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3415

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3415

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VINCENT <del>ZIPP</del> <del>DELMUNDA</del> ZIPP		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 29 70 10:49 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5/27/1915		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 216 09 1472	
18. INFORMANT ANGELA ZIPP		ADDRESS 127 E. GITTINGS ST.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-30-70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-2-70	
24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR McColly		ADDRESS 130 E. Fort Ave.	

ALL AMERICAN COMPANY

NEW COMPANY

VALLEY PARK CO

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 2em;">70 3416</span>	
L-300 <span style="font-size: 2em;">70 3416</span>		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">LATHE, MARIE ALVA</span>		MARCH 29, 1970 8:25P <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">ST AGNES HOSPITAL</span> <span style="font-size: 1.5em;">WILKENS &amp; CATON AVES.</span> <span style="font-size: 1.5em;">BALTIMORE, MARYLAND 21229</span>		A. STATE <span style="font-size: 1.5em;">MD.</span> B. COUNTY <span style="font-size: 1.5em;">19-03</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.5em;">BALTIMORE</span>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.5em;">507 SOUTH VINCENT STREET 21223</span>	
5. SEX <span style="font-size: 1.5em;">FEMALE</span>	6. RACE <span style="font-size: 1.5em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">08 30 <del>19</del> 92</span>
		9. AGE (in years last birthday) <span style="font-size: 1.5em;">77 <del>78</del></span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">HOUSEWIFE</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">MARYLAND</span>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">CHARLES <del>WILKINS</del> FISHER</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">FLORENCE ?</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">213 54 0256</span>	
		17. INFORMANT <span style="font-size: 1.5em;">BALTIMORE, MARYLAND</span> <span style="font-size: 1.5em;">ST AGNES RECORDS WILKENS &amp; CATON AVES</span>	
18. <span style="font-size: 1.5em;">352X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Acute Generalized Peritonitis</span> DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Strangulated Sigmoid</span> (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.5em;">Unresolving Pulmonary Embolism</span>	
19A. DATE OF OPERATION <span style="font-size: 1.5em;">3-29-70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">Strangulated sigmoid</span>	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">NO</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <span style="font-size: 1.5em;">XIX</span> (this hospital) attended the deceased from <span style="font-size: 1.5em;">MARCH 26</span> , 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">MARCH 29</span> , 19 <span style="font-size: 1.5em;">70</span> that <span style="font-size: 1.5em;">XIX</span> (we) last saw the deceased alive on <span style="font-size: 1.5em;">MARCH 29</span> , 19 <span style="font-size: 1.5em;">70</span> and that in <span style="font-size: 1.5em;">XIX</span> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <span style="font-size: 1.5em;">did not</span> view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">Romualdo P. Dator, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">3-29-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Romualdo P. Dator, M.D.</span>		23D. ADDRESS <span style="font-size: 1.5em;">ST AGNES HOSPITAL WILKENS &amp; CATON AVES.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">BURIAL</span>		24B. DATE <span style="font-size: 1.5em;">04/02/70</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Baltimore Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">APR 1 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Walters Funeral Home Pratt &amp; Stricker</span>		ADDRESS <span style="font-size: 1.5em;">Sts.</span>	

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It details the steps involved in setting up a robust system for data collection and analysis. This includes identifying the key areas of focus, selecting appropriate tools and technologies, and training staff to ensure they are equipped to handle the data effectively. The goal is to create a seamless process that allows for easy access and interpretation of the information.

3. The third part of the document addresses the challenges faced during the implementation phase. It acknowledges that there may be resistance to change or a lack of resources, but it provides strategies to overcome these obstacles. By fostering a culture of collaboration and providing necessary support, the organization can successfully integrate these practices into its daily operations.

4. The final part of the document summarizes the key findings and conclusions. It reiterates the importance of continuous monitoring and evaluation to ensure that the system remains effective over time. The document concludes by expressing confidence in the organization's ability to achieve its goals through the implementation of these practices.

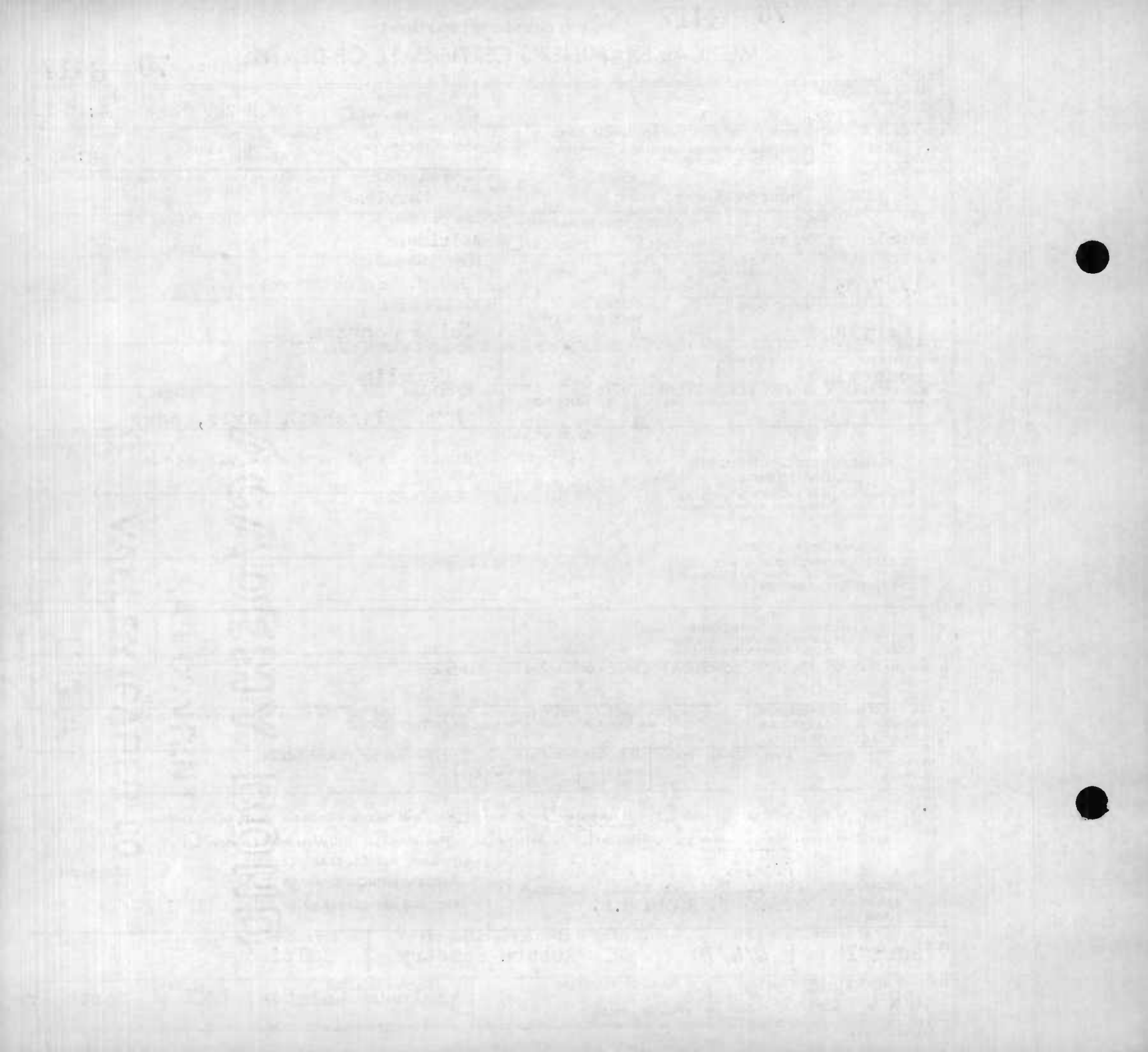
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3417

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELIZA FAGAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1970</b> Hour <b>4:20 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>320 N. Monroe Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 30, 1970</b> Hour <b>4:20 P.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1/27/05</b>		10. AGE (In years lost birthday) <b>65</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Culla Johnson</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-01</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Caroline</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs Elizabeth Davis, same</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/31/70</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/4/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore M</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W north Ave</b>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-363		70 3418		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3418	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Patricia Edwards</i>		2. DATE AND HOUR OF DEATH <i>March 26, 1970</i>		2:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>District of Columbia</i> B. COUNTY <i>V-48</i>		C. CITY OR TOWN <i>Washington D.C.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hosp. 501 N. Broadway Balt. Md.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>820 BARNABY Street S.E.</i>					
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-17-54</i>	9. AGE (In years last birthday) <i>15</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>student</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>M.S.</i>		
13. FATHER'S NAME <i>Virgil Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Edna White</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Renal Failure</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <i>Metabolic imbalance electrolyte abnormality</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2-</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>March 3 1970</i> to <i>March 26 1970</i> that (I) (we) last saw the deceased alive on <i>March 25 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M. Schumacher M.D.</i>		23B. DATE SIGNED <i>3/26/70</i>		23C. PHYSICIAN'S NAME (Type) <i>MITCHELL D. SCHWARZ M.D.</i>		23D. ADDRESS <i>2526 D Rellim Road Balt. Md. 21207</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>-</i>		24B. DATE <i>3-30-70</i>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <i>Ayden N.C.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 1 1970</i>		25B. NAME OF REGISTRAR <i>Patricia Edwards</i>		25C. FUNERAL DIRECTOR <i>FRAZIER'S F.H. 389 R.T. Ave. N.W.</i>		ADDRESS			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3419

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Howard L. Donovan, Sr. HOWARD DONOVAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 28, 1970 6:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4-7-70 4-27-70		3. DATE PRONOUNCED DEAD Month Day Year Hour March 28, 1970 6:40 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH May 24, 1912	10. AGE (In years last birthday) 57	E. STREET AND NUMBER 6900 North Point Road	
11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME David P. Donovan	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		14B. KIND OF BUSINESS OR INDUSTRY Tavern Owner	
15. MOTHER'S MAIDEN NAME Frances L. Webb		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213-09-3519		18. INFORMANT (Wife) 6900 North Point Rd. Mrs. Helen N. Donovan, Edgemere, Md. 21219	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6900 North Pt. Rd. (above tavern) 22D. TIME OF INJURY (APPROX.) 3:30-4:00 (about) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Shot self I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. DATE SIGNED March 29, 1970 EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/31/70	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. Apr 1 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	

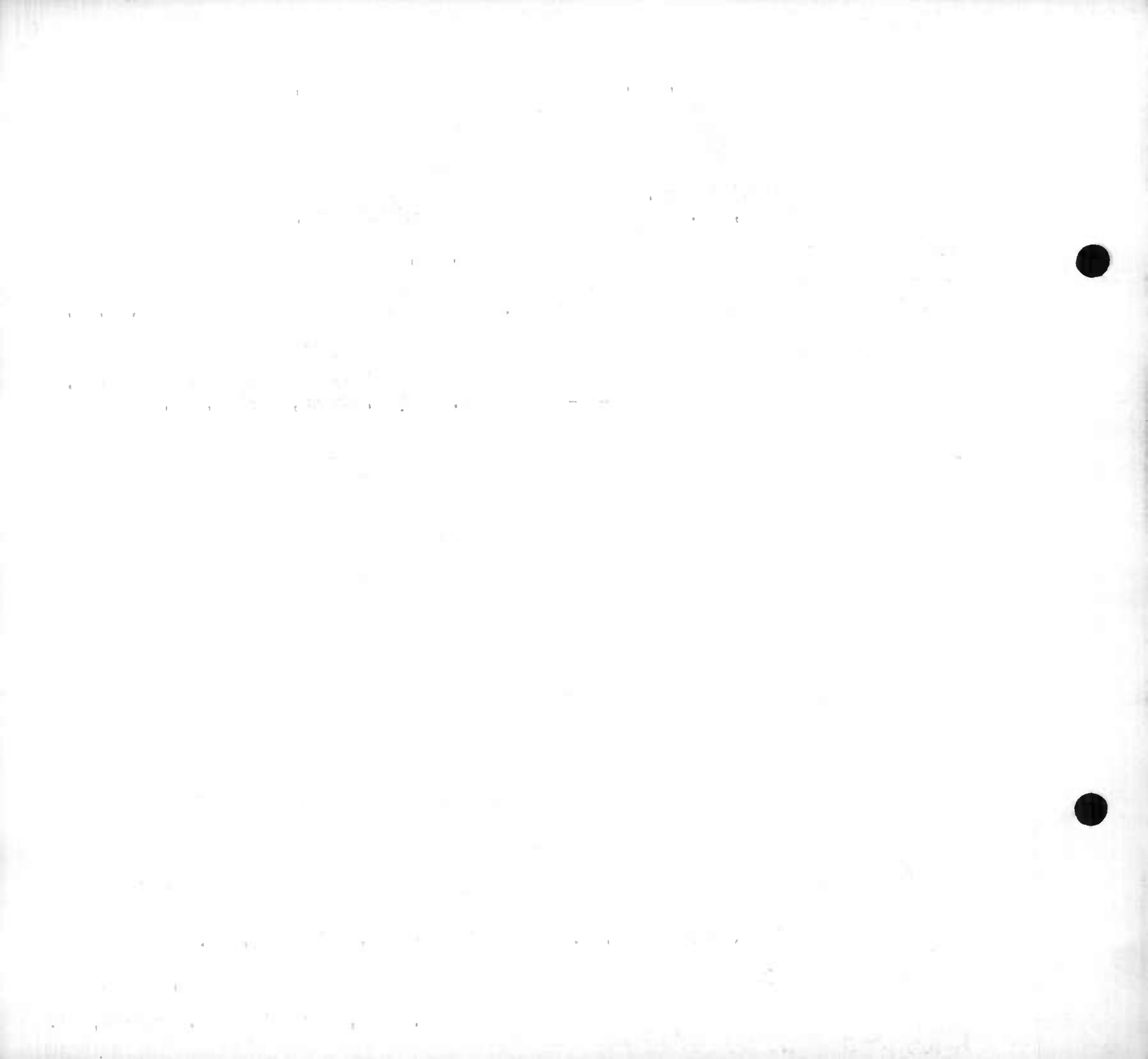
Letter from M.E.'s office

4-7-70 M.H.  
7-27-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

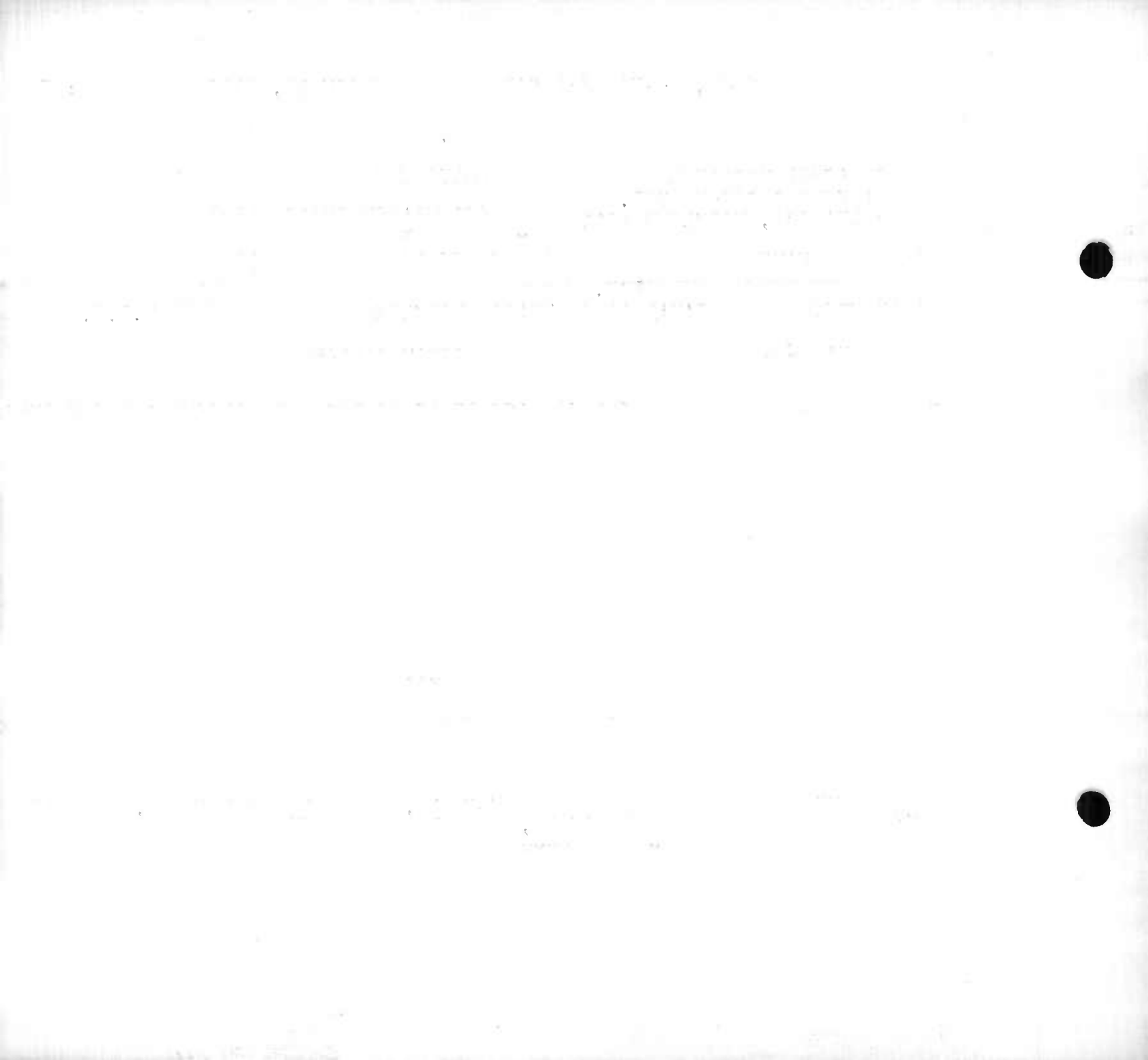
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3420</u>	
M-250 70 3420		BIRTH NO. <u>70 3420</u>			
1. NAME OF DECEASED (Type or Print) <u>Frank McNew, Sr.</u>			2. DATE AND HOUR OF DEATH <u>March 27, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>6213 Danville Ave. Baltimore, Md.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>26-36</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Dec. 23, 1897</u>			9. AGE (in years last birthday) <u>72</u>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Frank McNew</u>		
14. MOTHER'S MAIDEN NAME <u>Ella Smith</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-09-2095</u>			17. INFORMANT (Wife) <u>6213 Danville Ave.</u> <u>Mrs. Ruth C. McNew, Balto. Md.</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 4, 1949</u> to <u>March 27, 1970</u> that (I) (we) last saw the deceased alive on <u>March 25, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David H. Andrew M.D.</u>				23B. DATE SIGNED <u>3/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>David H. Andrew M. D.</u>				23D. ADDRESS <u>322 Kerneway, Baltimore, Md. 21212</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Carmel Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>Apr 1 1970</u>			
25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>C-465</span> <span>70 3421</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>70 3421</u>	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>COLLERAN, MARTIN FRANCIS</b>		2. DATE AND HOUR OF DEATH <b>MARCH 29, 1970 9:25P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>08 05 98</b>		9. AGE (in years last birthday) <b>71</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSTRUCTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CIVIL AERONAUTICS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MARTIN Colleran</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CALLAHAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>522 58 8150</b>		17. INFORMANT ADDRESS <b>50 ST AGNES RECORDS WILKENS &amp; CATON AVES</b>	
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <b>Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Bronchopneumonia @ lower lobe</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>XX</del> (this hospital) attended the deceased from <u>MARCH 18</u> , 19 <u>70</u> to <u>MARCH 29</u> , 19 <u>70</u> that <del>XX</del> (we) lost saw the deceased alive on <u>MARCH 29</u> , 19 <u>70</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Robert V. Luna</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Vailley, M.D.</b>				23D. ADDRESS <b>St. Agnes Hospital-Wilkins &amp; Caton</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Vailley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Sterling Funeral Estate</b> ADDRESS <b>756 Edmondson Ave. Catonsville, Md. 21228</b>			

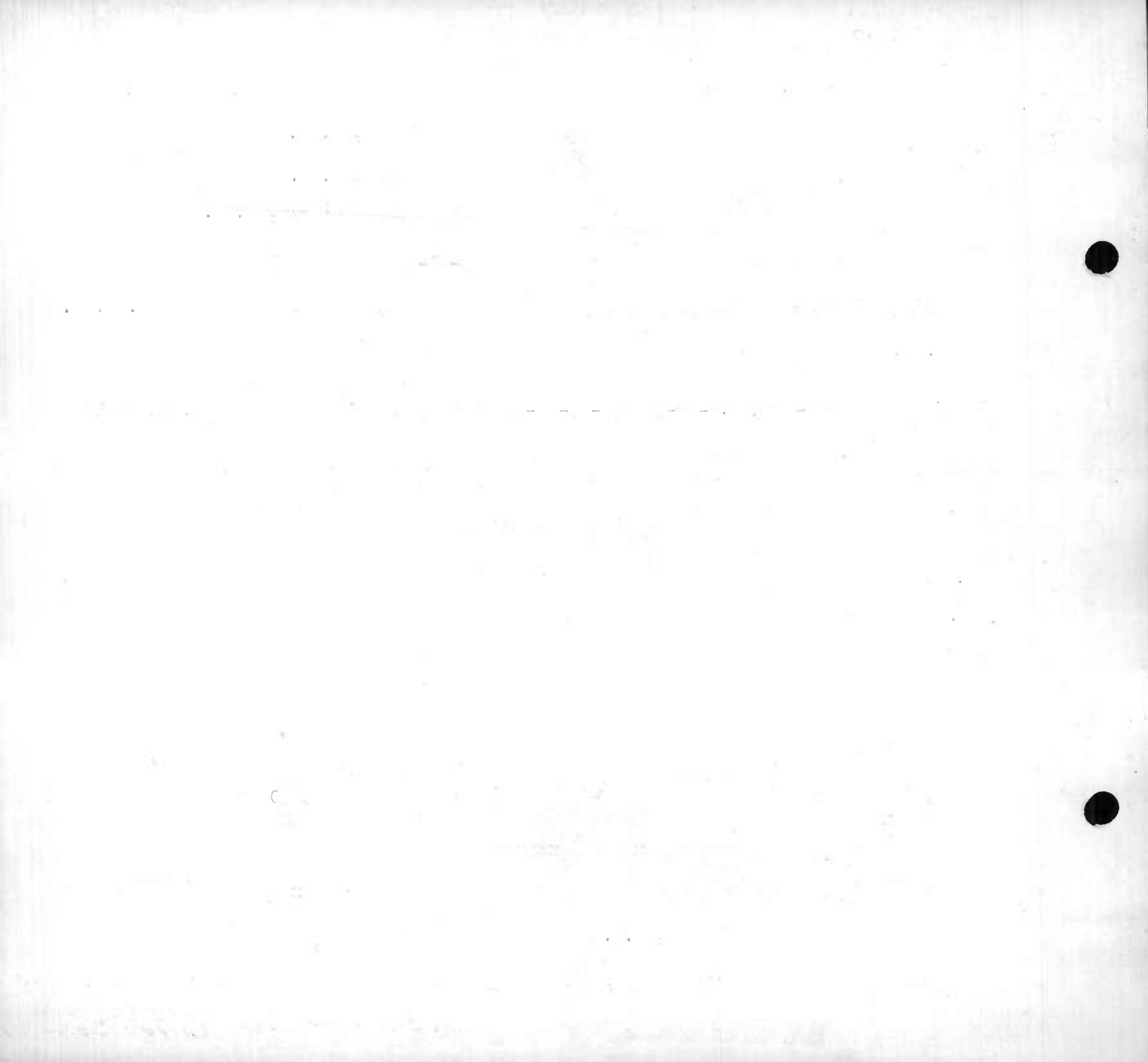




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>C-416</span> <span>70 3422</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 70 3422</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>CLIFFORD, Park M</b>		2. DATE AND HOUR OF DEATH <b>26 MARCH 1970 6:30P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>WASHINGTON, D. C.</b> B. COUNTY <b>V-48</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 2218</b>		C. CITY OR TOWN <b>WASHINGTON, D. C.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>330 PEABODY STREET, N. W.</b>	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASION</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-96</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Representative Ret Emp. Union</b>		9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>		11. BIRTHPLACE (State or foreign country) <b>MT VERNON, MISSOURI</b>	
13. FATHER'S NAME <b>A. C. CLIFFORD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 8-28-18 TO 12-13-18</b>		16. SOCIAL SECURITY NO. <b>579-05-84-11</b>	
17. INFORMANT <b>VA HOSPITAL RECORDS</b>		ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Septic shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cellulitis</b> <b>Decubitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>1 week</b> <b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>NO</b> (this hospital) attended the deceased from <b>25 MARCH 1970</b> to <b>26 MARCH 1970</b> that <b>NO</b> (we) last saw the deceased alive on <b>26 MARCH 1970</b> and that in <b>NO</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>NO</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>3/27/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER SMITHWICK, M.D.</b>		23D. ADDRESS <b>3900 LOCH RAVEN BLVD</b> <b>BALTIMORE, MARYL ND 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/31/70</b>	24C. NAME of CEMETERY or CREMATORY <b>Pine Grove Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>South Yarmouth, Mass</b>
25A. DATE REC'D BY HEALTH/DEPT. <b>APR 1 1970</b>	25B. NAME OF REGISTRAR <b>Place E. Johnson</b>	25C. FUNERAL DIRECTOR <b>W W Chambers, Inc</b> <b>8655 E-2 AVE</b> <b>Silver Spring</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3423</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">M-625 70 3423</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <span style="font-size: 1.2em;">ELIZABETH MORGAN</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="display: flex;"> <div style="border: 1px solid black; padding: 2px;">3/30/70</div> <div style="border: 1px solid black; padding: 2px;">3/30/70</div> <div style="border: 1px solid black; padding: 2px;">P</div> <div style="border: 1px solid black; padding: 2px;">5<sup>30</sup></div> <div style="border: 1px solid black; padding: 2px;">A</div> <div style="border: 1px solid black; padding: 2px;">M.</div> </div> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33 Johns Hopkins</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span> <b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">BOLTY</span> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <span style="font-size: 1.2em;">MORGAN, ELIZABETH</span> <span style="font-size: 1.2em;">821 N. 02 28 07 18 WOLFE</span>		
<b>5. SEX</b> <div style="border: 1px solid black; padding: 2px; text-align: center;">F</div>	<b>6. RACE</b> <div style="border: 1px solid black; padding: 2px; text-align: center;">N</div>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="border: 1px solid black; padding: 2px; text-align: center;">?</div>	<b>9. AGE</b> (In years lost birthday) <div style="border: 1px solid black; padding: 2px; text-align: center;">77</div>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">N. CAROLINA</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Fred Stone</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Spice Stone</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mary Scarborough 821 N. WOLFE</span> <b>ADDRESS</b>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div style="flex: 1;"> <b>(A) IMMEDIATE CAUSE</b>            DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">CVA'S</span>   <b>(B) HASLED</b>            DUE TO, OR AS A CONSEQUENCE OF:   <b>(C)</b> </div> <div style="flex: 0.5;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">1924</span>   <span style="font-size: 1.2em;">1924</span> </div> </div>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <div style="border: 1px solid black; padding: 2px; text-align: center;">0</div>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <div style="border: 1px solid black; padding: 2px; text-align: center;">NO</div>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">3/13</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>to</b> <span style="font-size: 1.2em;">3/30</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">3/30</span> <b>19</b> <span style="font-size: 1.2em;">70</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Thomas Inn</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/30/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">THOMAS INN</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Crem</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">4-1-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Mt Auburn Cmt</span>	
<b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">Bolto Md</span>		<b>24E. STATE</b> (State)		<b>25A. DATE REC'D. BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">APR 1 1970</span>	
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. ...</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Clayton Wilson</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">on Brantly Rd</span>			



G-612

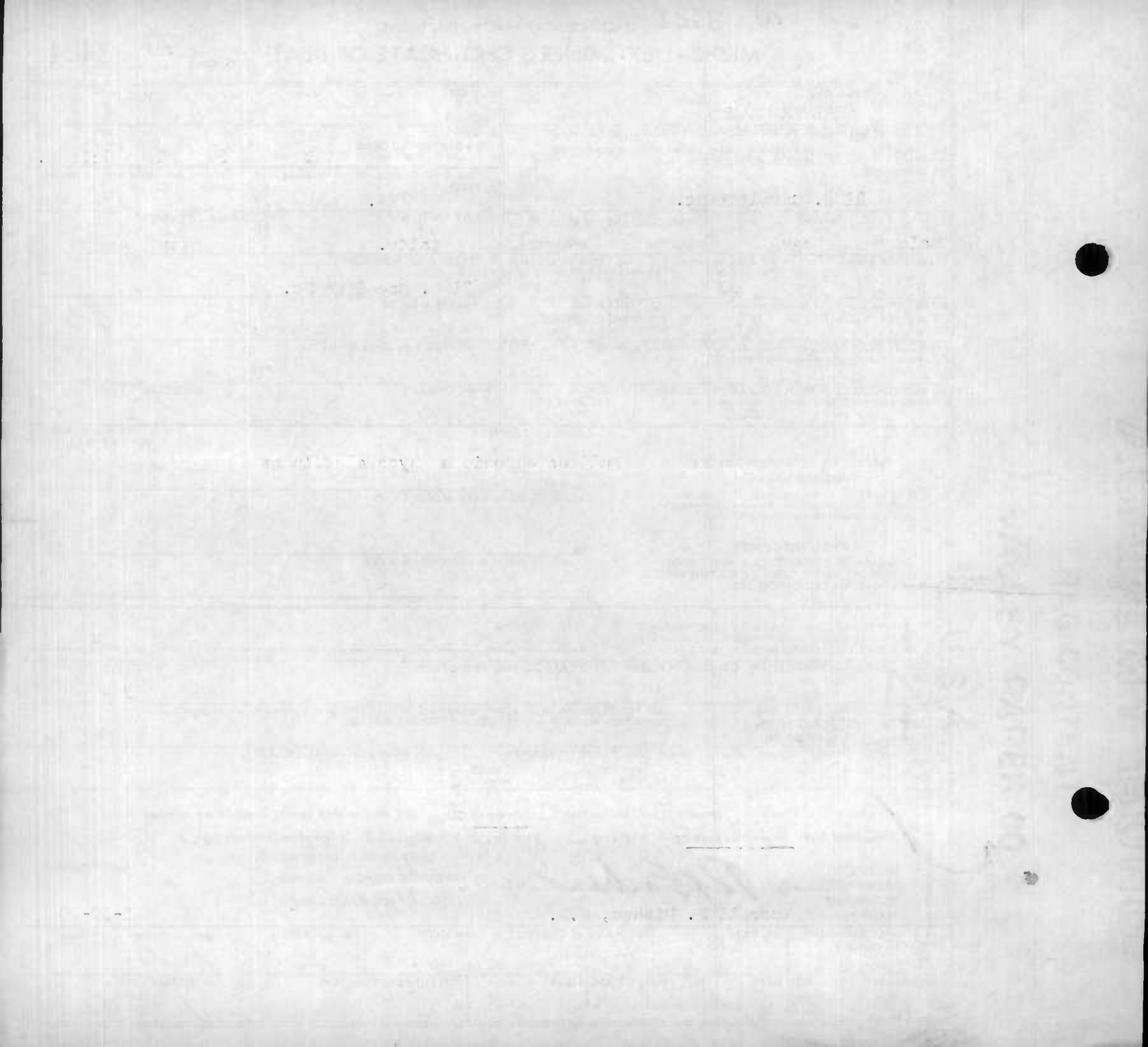
70 3424

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3424

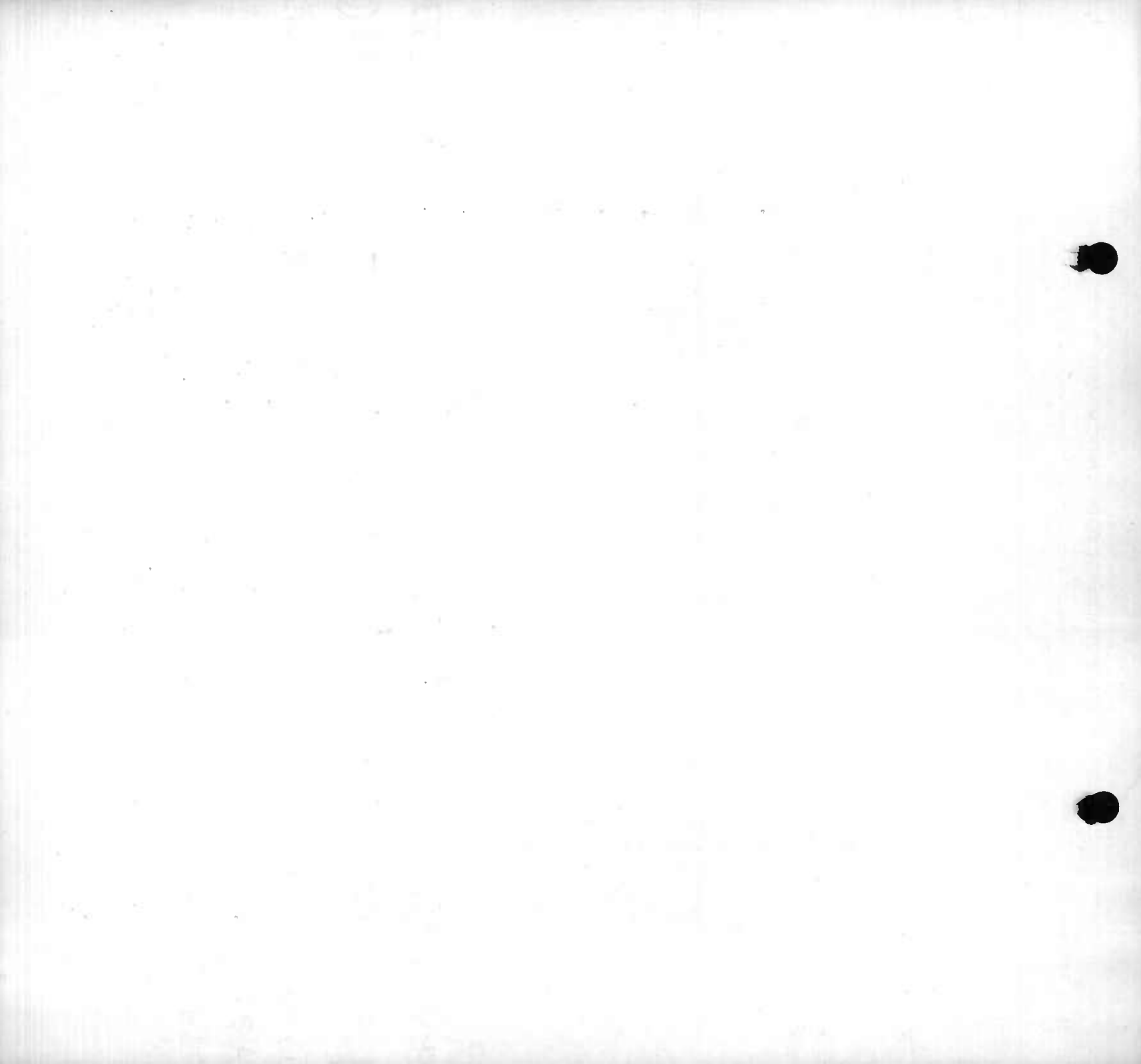
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALTER GRAVES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 21 N. Caroline St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 30 70 7:55 A.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 3-01	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-21-1916		10. AGE (In years lost birthday) 53		E. STREET AND NUMBER 21 N. Caroline St.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Groves	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Marie Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 218-03-0639		18. INFORMANT ADDRESS Marie Groves, 1401	
19. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bullous chronic emphysema of lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 3-30-70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-1-70		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Elroy O. Wilson 1100 Brambley Rd	
24D. LOCATION (City, town, or county) (State) Balto Md					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0-242 70 3425				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3425	
1. NAME OF DECEASED (Type or Print) <b>MALISSIE OGLESBY</b>				2. DATE AND HOUR OF DEATH <b>3-30-70 2:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>651 W. MULBERRY ST.</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4-1-14</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.A</b>	
13. FATHER'S NAME <b>Frank Archie</b>				14. MOTHER'S MAIDEN NAME <b>CECILIA ARCHER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-44-0904</b>		17. INFORMANT <b>BCH Records</b>		ADDRESS <b>4940 Eastern Ave. Baltimore, Md. 21224</b>	
18. <b>250101</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DIABETIC ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>DIABETES MELLITUS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CVA @</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>- days</b> <b>YRS.</b> <b>MOs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>URINARY TRACT INFECTION</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-21-70</b> to <b>3-30-70</b> , that (I) (we) last saw the deceased alive on <b>3-30-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rene P. de los Santos</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-30-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RENE P. DE LOS SANTOS</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4-3-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Carmel</b>		24D. LOCATION (City, town, or county) (State) <b>Balti Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>C. Wilson</b>		ADDRESS <b>1001 Bramley Rd</b>	

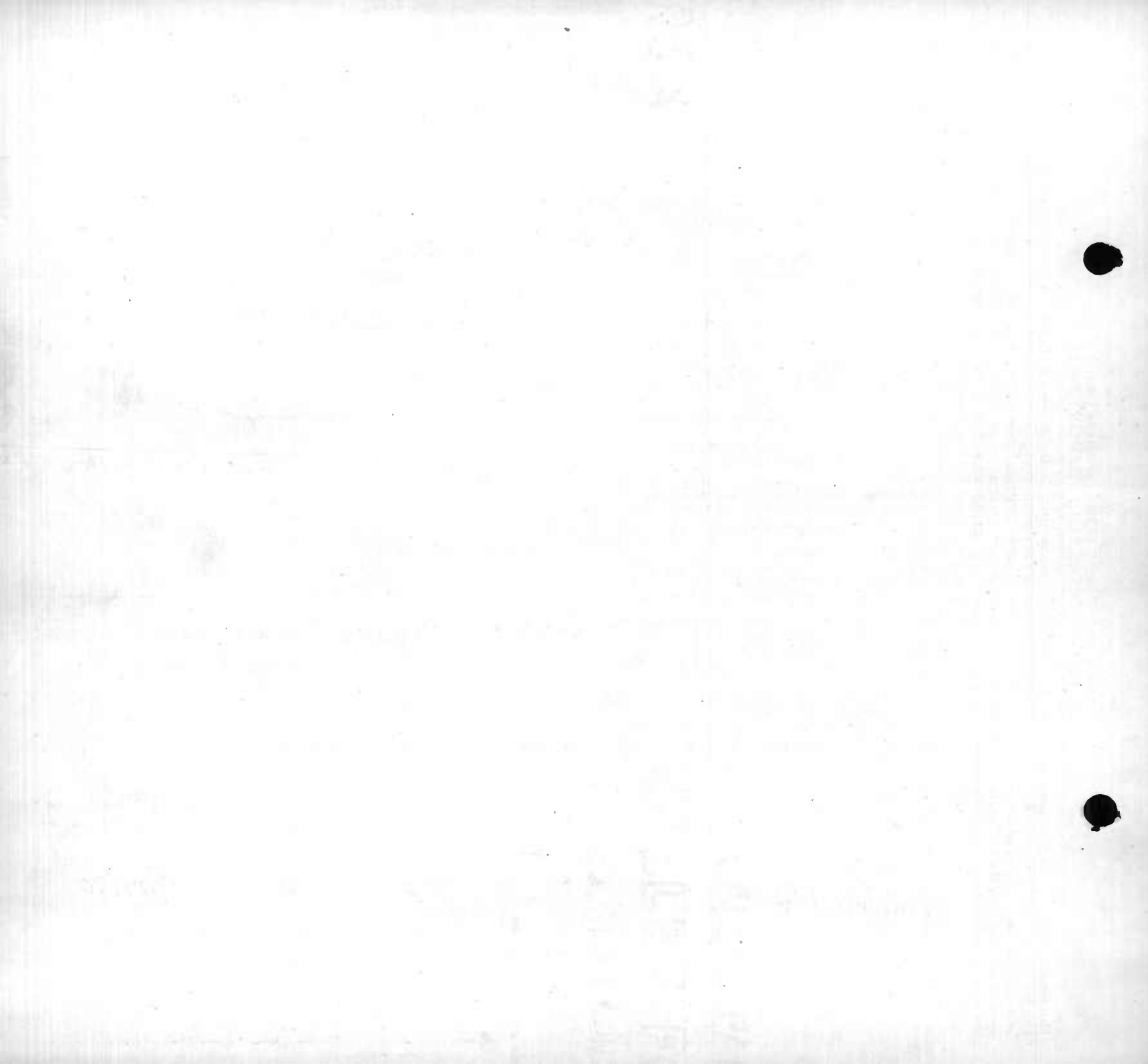




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

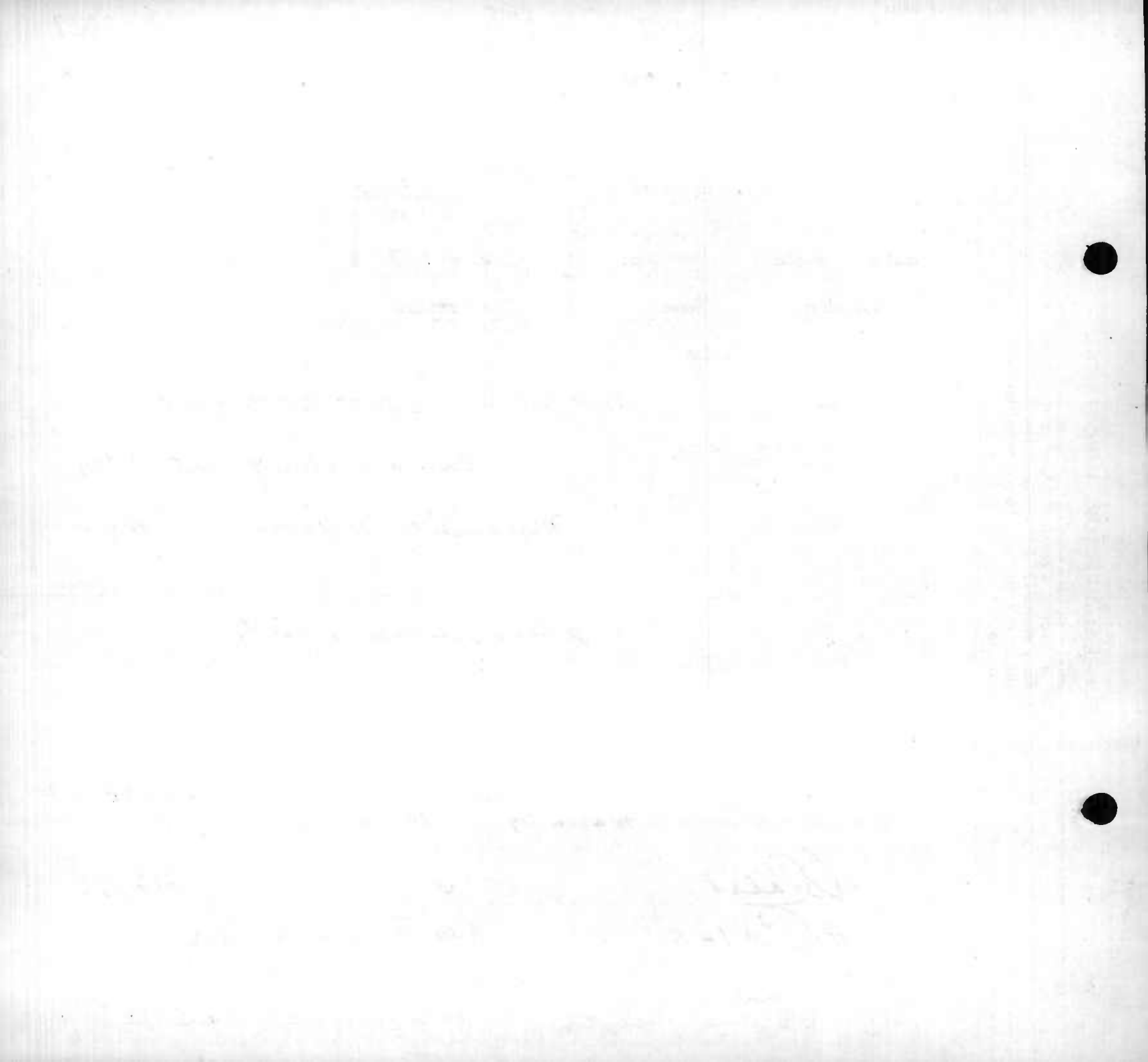
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
B-632 70 3426				70 3426		70 3426	
B-632 70 3426				70 3426		70 3426	
1. NAME OF DECEASED (Type or Print) <b>ANDREW BRIDGES</b>				2. DATE AND HOUR OF DEATH <b>12 15 3/27/70 12 15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>22 N. MORLEY STREET</b> 20-47			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/01</b>	9. AGE (In years lost birthday) <b>68</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Darlington, S. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>HENRY BRIDGES</b>			
14. MOTHER'S MAIDEN NAME <b>HENRIETTA</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-03-1806</b>				17. INFORMANT <b>Comme Bridges Lane</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOGENIC CARCINOMA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>							
21A. DATE OF OPERATION <b>0</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <b>NO</b>		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21E. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21F. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21H. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21I. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21J. HOW DID INJURY OCCUR?			
22. I certify that <del>it</del> (this hospital) attended the deceased from <b>3/25/70</b> 19 <b>70</b> to <b>3/27</b> 19 <b>70</b> , that <del>it</del> (we) last saw the deceased alive on <b>3/26</b> 19 <b>70</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>it</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Karl J. Kramer</b>				23B. DATE SIGNED <b>3/27/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>KARL J. KRAMER</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-31-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cmt</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Elroy Wilson, owner</b>		ADDRESS <b>1001 E. Main St., Baltimore, Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

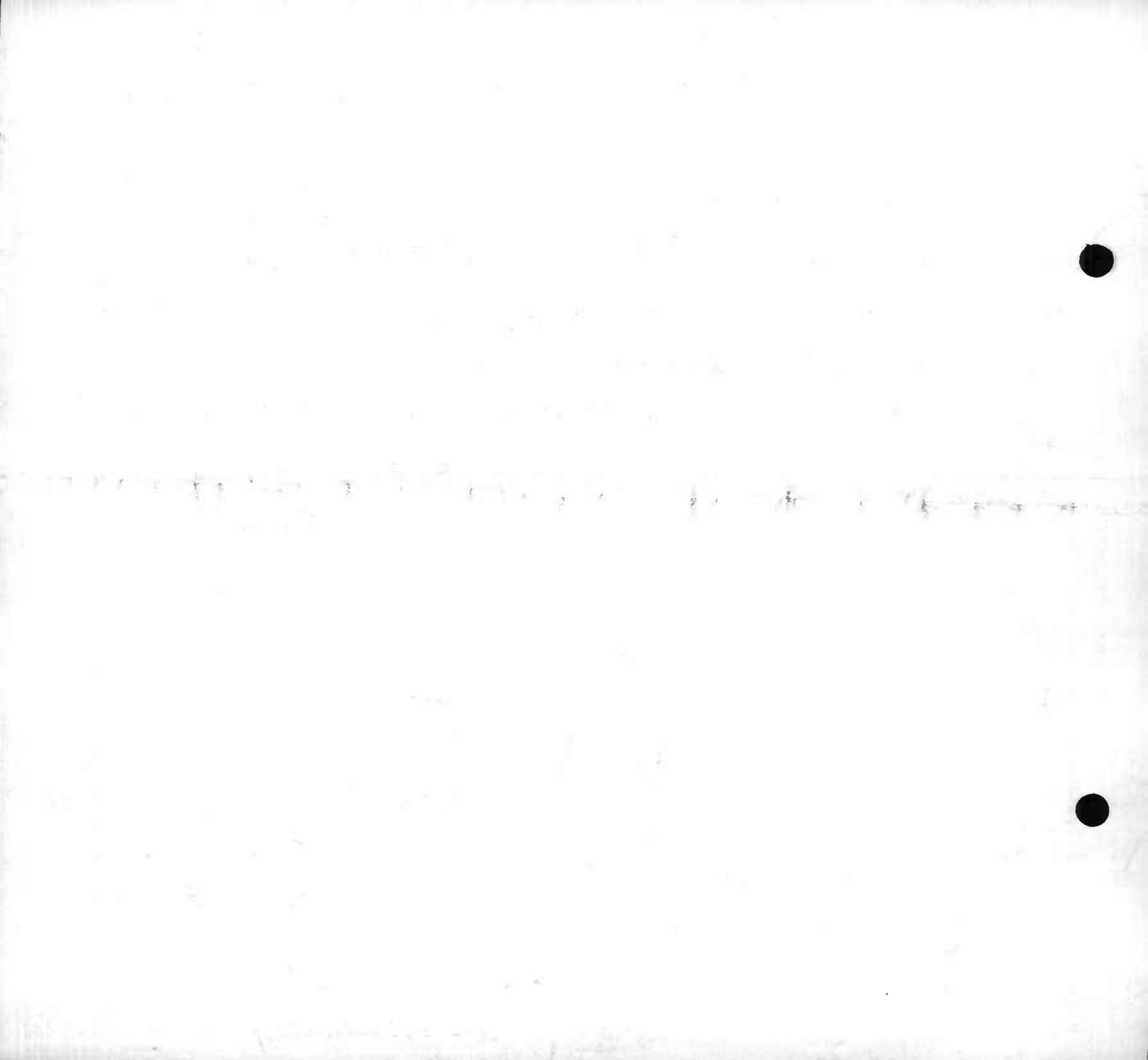
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3427</u>
70 3427		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lillian M. Earley</u>		
		2. DATE AND HOUR OF DEATH <u>Mar. 30 1970</u> <u>7 A M</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-03</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>306 S. Gilmore St</u>		C. CITY OR TOWN <u>Balto</u>
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>306 S Gilmore St</u>		
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28 1887</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Thater</u>		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>213 54 1860</u>		17. INFORMANT <u>Wilbur C Earley</u>
		ADDRESS <u>2916 Kingsley St</u>		
18. <u>412.31</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Acute d. of the heart</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Myocarditis chronic</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Arterio sclerosis senility</u>		
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2</u> 19 <u>70</u> to <u>March 30</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Alcala's</u>		23B. DATE SIGNED <u>3/31/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>A. CAIAS</u>		23D. ADDRESS <u>6411 Frederick Ave</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-2-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc 160 Hollins St</u>
		ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

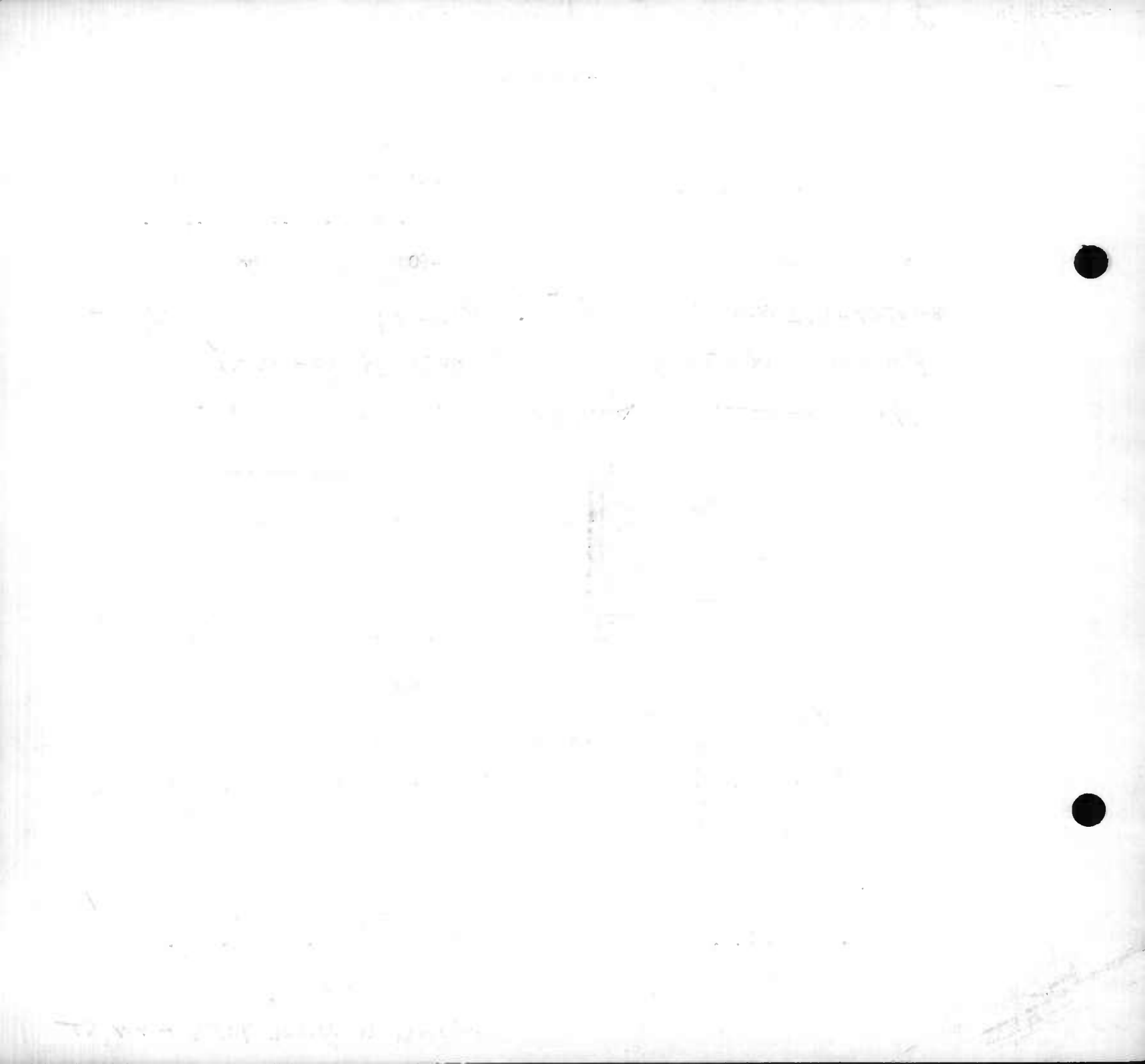
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3428</u>	
BIRTH NO. <u>B-432</u> <u>70 3428</u>		1. NAME OF DECEASED (Type or Print) <u>BALTZEGAR-BURNETT</u>		2. DATE AND HOUR OF DEATH <u>3/27/70</u> <u>11<sup>30</sup> PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-11</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>city Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel (Retired)</u>		8. DATE OF BIRTH <u>1-28-1901</u> 9. AGE (in years last birthday) <u>69</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Philip Baltzegar</u>	
14. MOTHER'S MAIDEN NAME <u>VERGINA ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-038577</u>	
17. INFORMANT <u>ANNE BALZEGAR-Same</u>		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCARD - hypertension</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>years.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/19/70</u> 19 <u>70</u> to <u>3/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Hoodazar, M.D.</u>				23B. DATE SIGNED <u>3/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. HOODAZAR, M.D.</u>				23D. ADDRESS <u>Sinai Hospital, Baltimore - MD. 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/3/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>mt. Auburn</u>	
24D. LOCATION <u>Balto. Md</u>		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Allen S. Chaturani, Jr.</u>	
25D. ADDRESS <u>1701 Mt. Calhoun St.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
R-220 70 3429		70 3429		70 3429	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John Rojek - John Rojek		3/30/70 12:15			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		A. STATE Maryland		B. COUNTY 26-10	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital Baltimore, Md. 21224 4940 Eastern Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3244 E. Balto. St., Balto., Md. 21224			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-90	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10B. KIND OF BUSINESS OR INDUSTRY Retired & Seal Co.		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME PAUL ROJEK		14. MOTHER'S MAIDEN NAME MARY KOWALSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 7-4577		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Staphylococcal Pneumonia IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Brain Syndrome - ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Bar skull fracture chronic brain syndrome			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3244 E. Baltimore St.	
21D. TIME OF INJURY (APPROX.) 1-23-70 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell out of bed at home	
22. I certify that (I) (this hospital) attended the deceased from 1/26 1970 to 3/30 1970 that (I) (we) last saw the deceased alive on 3/26/70 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Krush M.D.		23B. DATE SIGNED 3/30/70			
23C. PHYSICIAN'S NAME (Type) C. Krush, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/2/70		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 1 1970		24F. NAME OF REGISTRAR Robert E. Fisher, R.D.	
24G. FUNERAL DIRECTOR George A. Weber		24H. ADDRESS 705 S. ANN ST			





# FUNERAL DIRECTOR: IMPORTANT

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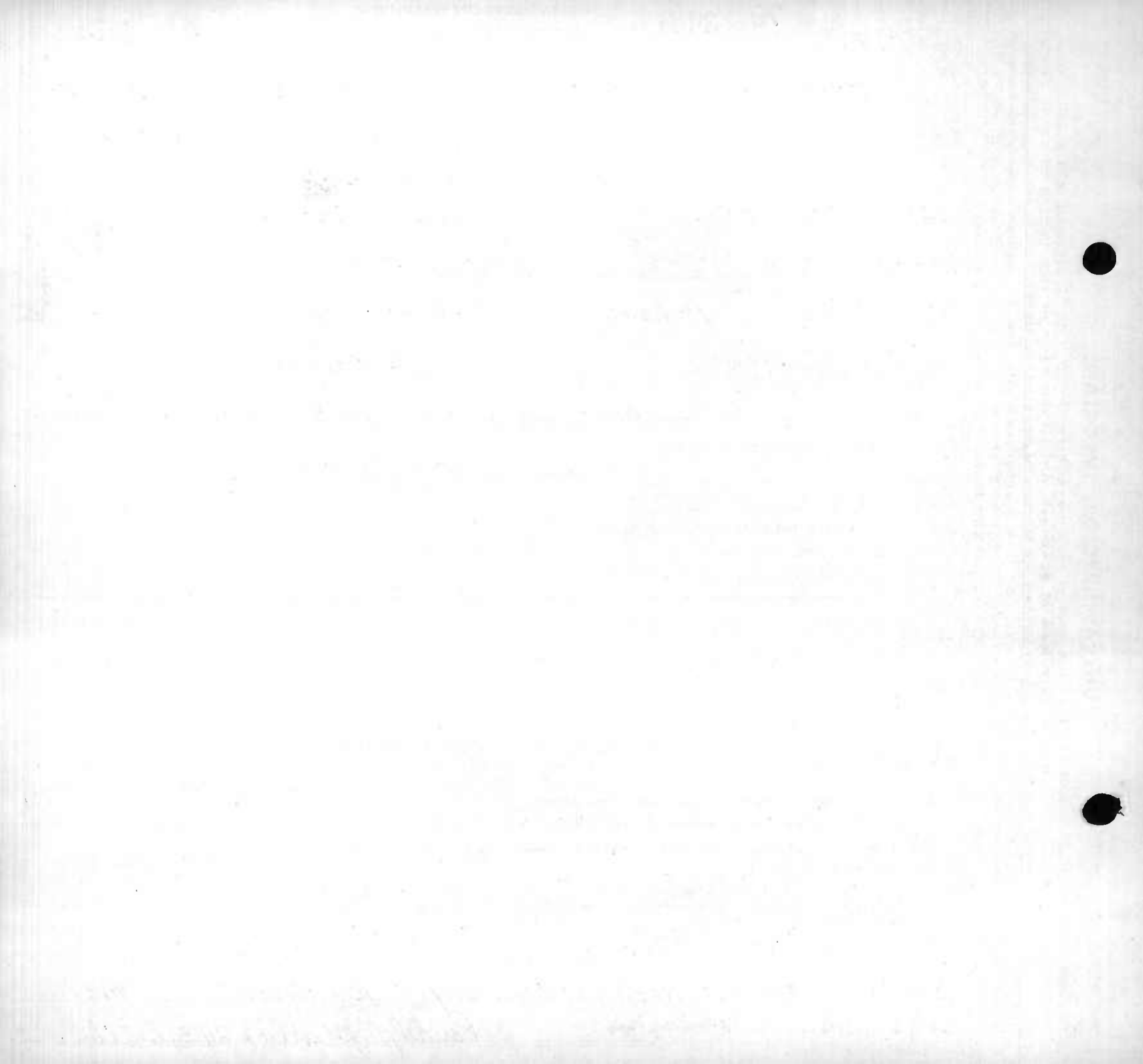
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3430</span>	
D-120 <span style="font-size: 1.5em;">70 3430</span> CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Walter Clifford Davis</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/28/70 1 6<sup>20</sup> P M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">25-05</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">University of Md. Hospital 38 Baltimore 1, Md.</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">3308 Hawkins Point Rd</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12-18-06</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">63</span>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Painter</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Davison Chemical</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Ga.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">Lucious Davis</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Solomon</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-07-7077</span>		17. INFORMANT <span style="font-size: 1.2em;">Hospital Chart</span>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.2em;">Cardiorespiratory Failure</span> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Marked Ascites, anasarca</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Metastatic Ca of Prostate</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 1 wk</span> <span style="font-size: 1.2em;">5 1 wk</span> <span style="font-size: 1.2em;">&gt; 6 mos.</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/26</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">John M. Steffy MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">3/28/70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">John M. Steffy MD</span>
24A. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			24B. DATE <span style="font-size: 1.2em;">4-1-70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Calvary Cemetery</span>
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Anne Arundel Co., Md.</span>			25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 1 1970</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, Jr.</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Randolph J. Collick</span>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 3431</b>
BIRTH NO. <b>V-616 70 3431</b>				
1. NAME OF DECEASED (Type or Print) <b>Anna Louise Varborough</b>		2. DATE AND HOUR OF DEATH <b>3-26-70 7:55 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>10-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1220 N. Spring St.</b>				
5. SEX <b>Female</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-1919</b>	9. AGE (In years last birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Hicktower</b>		
14. MOTHER'S MAIDEN NAME <b>Mary E. Harris</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-16-5104</b>		17. INFORMANT <b>Charles Varborough</b> ADDRESS <b>1220 N. Spring St.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Brest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 21 1969</b> to <b>March 26 1970</b> , that (I) (we) last saw the deceased alive on <b>March 25 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>F. K. Adams</b>		23B. DATE SIGNED <b>March 27-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>F. K. ADAMS</b>		23D. ADDRESS <b>1222 N. Caroline St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-30-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State) <b>Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b> ADDRESS <b>2431 E. Oliver St.</b>



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **70 3432**

BIRTH NO.

<b>1. NAME OF DECEASED</b> (Type or Print) <p align="center"><b>EFFIE R. RICHARDSON</b></p>		<b>2. DATE OF DEATH</b> Known <input type="checkbox"/> Month    Day    Year    Hour Estimated <input type="checkbox"/> 3    24    70    9:35 p.m.			
<b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2134 Pressman St.		<b>3. DATE PRONOUNCED DEAD</b> Month    Day    Year    Hour March    24,    1970    9:35 p.m.			
<b>6. SEX</b> Female		<b>7. RACE</b> Negro		<b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>9. DATE OF BIRTH</b> 3-15-1893		<b>10. AGE</b> (In years lost birthday) 77		<b>11. BIRTHPLACE</b> (State or foreign country) Halifax Co., Va.	
<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.B.		<b>13. FATHER'S NAME</b> Jessie Richardson			
<b>14. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Domestic		<b>15. MOTHER'S MAIDEN NAME</b> Annie Silver			
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>17. SOCIAL SECURITY NO.</b>		<b>18. INFORMANT</b> Mrs Susie Blow 1620 N. Broadway	
<b>19. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
<b>20A. DATE OF OPERATION</b> 0		<b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			
<b>22A. EXTERNAL CAUSE WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>	
<b>22D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>22F. HOW DID INJURY OCCUR?</b>	
<b>23. I certify that I held on Inquiry</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <i>Isidore Mihalakis</i> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> Isidore Mihalakis, M.D. <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> 3/25/70 <b>ASSOCIATE MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Removal		<b>24B. DATE</b> 3-27-70		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Richardson Cemetery, Brooklyn, N.C.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> APR 1 1970		<b>25B. NAME OF REGISTRAR</b> Robert E. Taylor, M.D.		<b>25C. FUNERAL DIRECTOR</b> Randolph J. Palk 2431 E. Oliver St.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3433</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 3433</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Galloway, William</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-31-70</span> <span style="font-size: 1.2em;">8<sup>35</sup> A</span> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">15-04</span>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">LUTHERAN HOSPITAL OF MD. 46</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">MALE</span>		6. RACE <span style="font-size: 1.2em;">N.</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <span style="font-size: 1.2em;">1894</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">unk.</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unk.</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">75</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">N.C.</span>	
18. <span style="font-size: 1.2em;">486X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Dehydration - Possible Pneumonia</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Daniel 1936 Ridgehill Ave.</span>		ADDRESS			
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-30</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3-31</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Violeta R. Gamara R MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3-31-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">VIOLETA R GAMARRA R MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">730 Ashburton St Bal MD 21216</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-3-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Auburn</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 1 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor MD</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">641 W. Barre St. CHARLES A. PICE</span>			

1911

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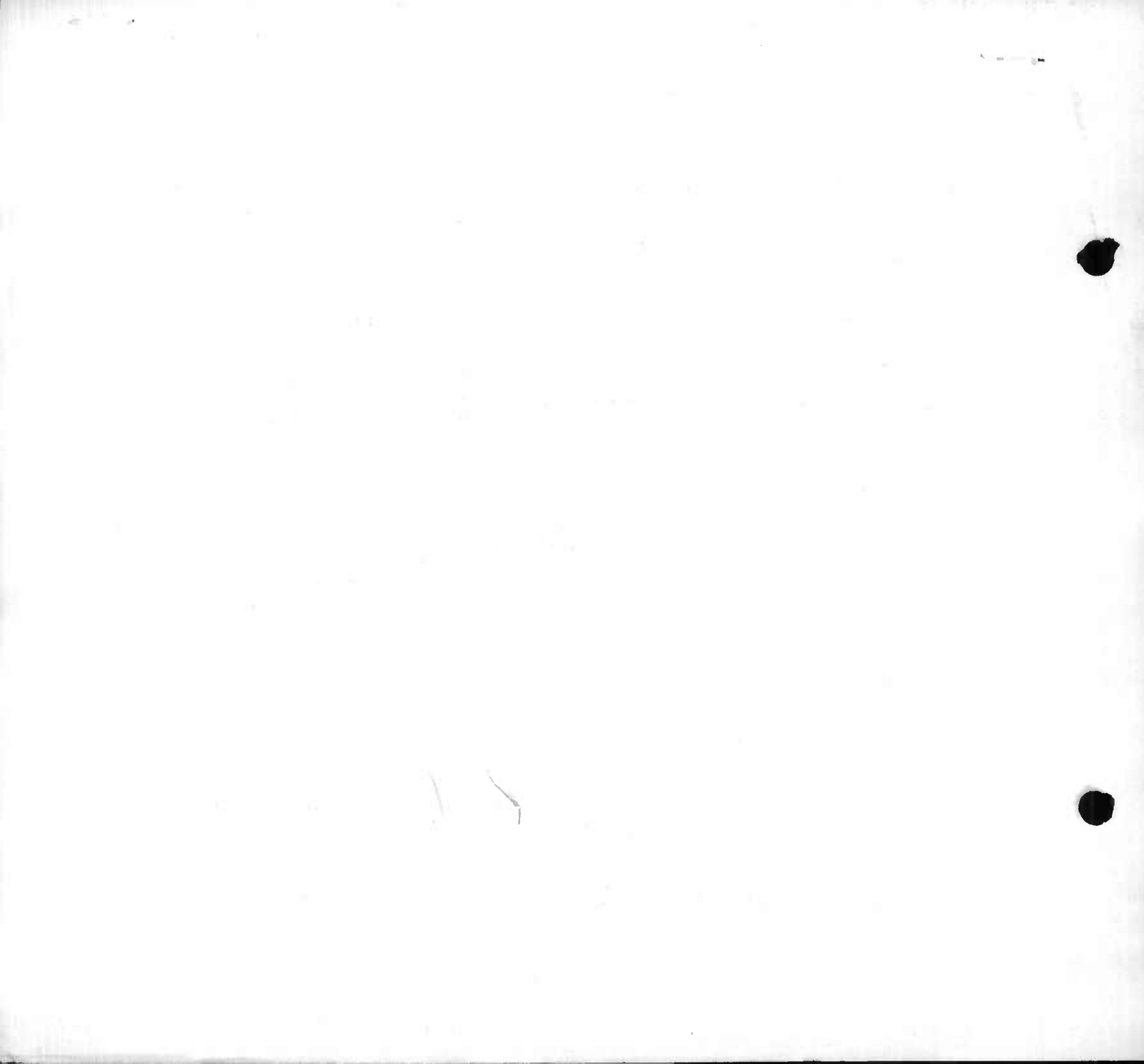
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 3434		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3434	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOHN E. Smith				3/26/70 1 7 <sup>30</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
University of Maryland Hospital 38				Md. Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. BIRTHPLACE (State or foreign country) 11. CITIZEN OF WHAT COUNTRY?			
Male Negro				12/24/86 83 Mt. Virginia U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
UNKNOWN				UNKNOWN			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Bob Smith				Adeline			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS			
UNKNOWN No				UNKNOWN 2601 Quantico Ave.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Probable Pulmonary Emboli 25 DAYS			
ANTECEDENT CAUSES				(B) ASCVD ?			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Congestive Heart Failure 34 DAYS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/26/70		No Neoplasm		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 2/24 1970 to 3/26 1970 that (I) (we) last saw the deceased alive on 3/26 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Charles L. Cromwell, M.D.				3/26/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-1-70		Mt. Auburn		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 1 1970		Robert E. Taylor, M.D.		CHARLES H. RICE 661 W. BARRE ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3435 BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH REG. NO. 70 3435

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GEORGE WILSON		3.30.70 15.25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
UNIVERSITY OF MARYLAND HOSPITAL		38 MARYLAND HOSPITAL		MARYLAND 23-01	
5. SEX		6. RACE		C. CITY OR TOWN	
M N		N		BALTIMORE	
7. MARRIED		NEVER MARRIED		D. INSIDE CITY LIMITS?	
WIDOWED		DIVORCED		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
				1005 LEADENHALL ST.	
13. FATHER'S NAME		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Joe Wilson		11-26-20		49	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
		217-16-7719		North Carolina	
17. INFORMANT		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
EARTHA Wilson		Fannie		U.S.A.	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Aspiration Pneumonia		48 hrs	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Carcinoma of Lung			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3.11.70		Carcinoma of Lung		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3.6.1970 to 3.30.1970 that (I) (we) last saw the deceased alive on 3.30.1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Garvey		3.30.70		GARVEY	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-3-70		Mt. Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 1 1970		Robert E. Farber, M.D.		CHARLES A. RICE 661 W. GARRE ST.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

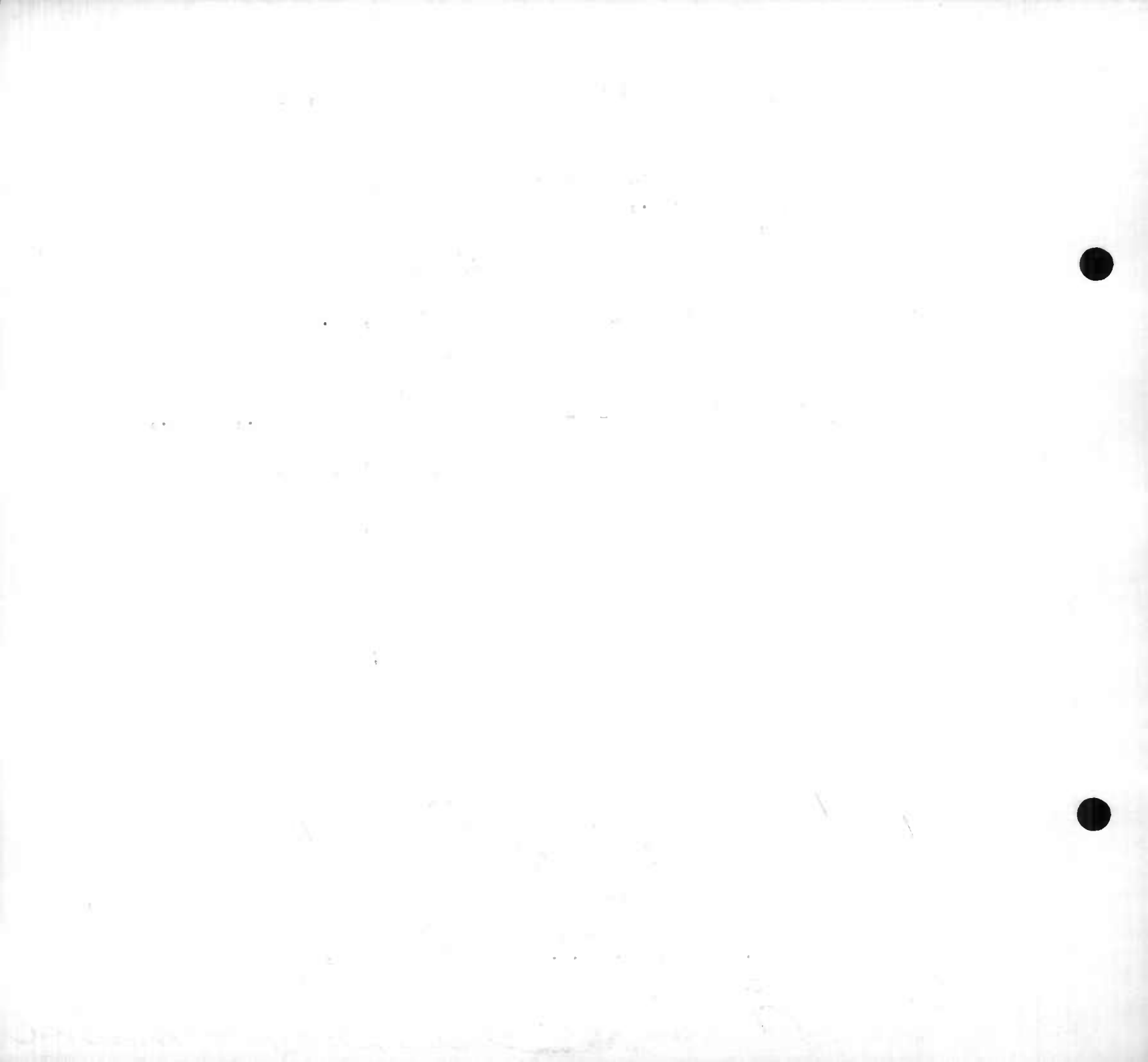
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3436</span>	
70 3436				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CIANCHETTA, CARMINE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-22-70 10 30 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission) A. STATE <span style="font-size: 1.2em;">26-07</span> B. COUNTY <span style="font-size: 1.2em;">BALTO. MD</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">49 NORTH CHARLES GENERAL HOSP</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO -</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <span style="font-size: 1.2em;">N. CHARLES ST &amp; 28th -</span>		
5. SEX <span style="font-size: 1.2em;">M.</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8-25-80</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">89</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">RETIRED</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ITALY</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">ITALIAN</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">SALVATORE CIANCHETTA -</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FILLIPE</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">180-01-8058</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">NORTH CHARLES HOSP</span>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 DAYS</span>		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ANEMIA</span>					
(B) GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF:					
(C) .....					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">ARTERIOSCLEROTIC HEART DISEASE</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-17</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3-22</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-22</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Ellen M. Conia</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3-22-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">B. HIGHSTEIN</span>				23D. ADDRESS <span style="font-size: 1.2em;">121 S HIGHLAND AVE, BALTO. M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Embalment</span>		24B. DATE <span style="font-size: 1.2em;">3/25/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Lorraine Park Mausoleum</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 1 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Joseph N. Zannino - 263 S. Conkling Street</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3437		REG. NO. 70 3437	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>McDANIEL, Charles Preston</b>				2. DATE AND HOUR OF DEATH <b>March 31, 1970 2:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>11/24/25</b>		9. AGE (In years last birthday) <b>44</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Preston McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Lively</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3/2/44 to 6/46</b>				16. SOCIAL SECURITY NO. <b>219-18-3079</b>		17. INFORMANT <b>VA Hospital Records</b>	
				ADDRESS <b>3900 Loch Raven Blvd., Balto., Md 21218</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Alcoholic hepatitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>Laennec's cirrhosis</b> <b>Chronic alcoholism</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>10 years</b> <b>20 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 27th 1970</b> to <b>March 31st 1970</b> that (I) (we) last saw the deceased alive on <b>March 31st 1970</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Perry G. Austin, Jr.</i>				23B. DATE SIGNED <b>March 31, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>PERRY G. AUSTIN, JR., M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Fredrick Rd. Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Fredrick J. Cook</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

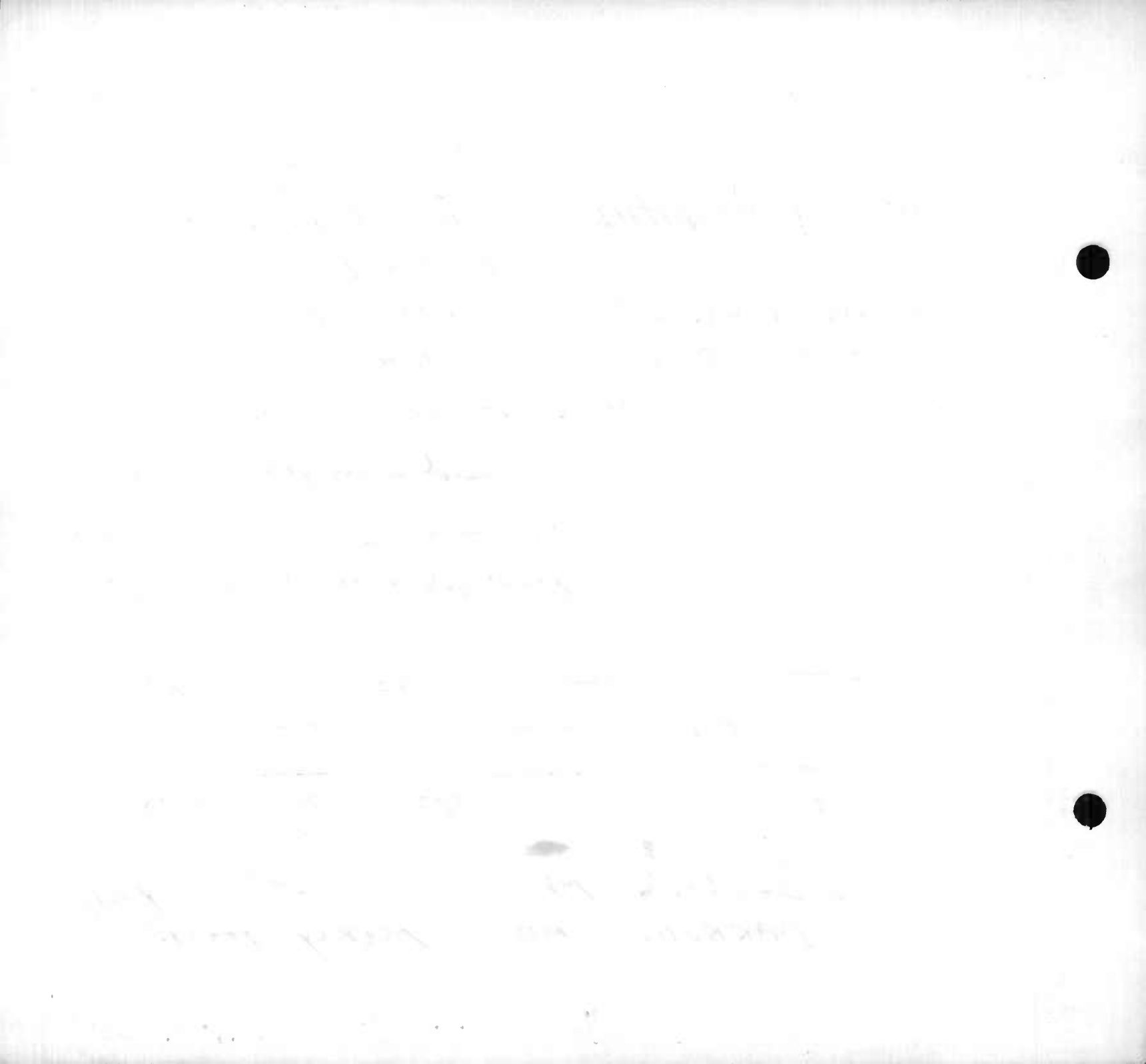
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3438</b>
BIRTH NO. <b>70 3438</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>MARY E. Bush</b> <i>Miss (Maime) Bush</i>		2. DATE AND HOUR OF DEATH <b>3-31-70 12:50 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Hoof Convent Home</b> <b>5313 Edmonson Ave. 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>and</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1321 Stonewood Rd. 27-39</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Hoof Convent Home</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 2 - 1880</b>	9. AGE (In years lost birthday) <b>89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hochschild, Kohns Co.</b>		11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. (American)</b>		13. FATHER'S NAME <b>Joshua M. Bush</b>		
14. MOTHER'S MAIDEN NAME <b>Christine Meyers</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss Florence M. Bush (Same)</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pirulatory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>A.S.C.V.D</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>3/31/1970</b> to <b>3/31/1970</b> , that (1) (we) last saw the deceased alive on <b>3/31/1970</b> and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>Adnan M. Sonmez</b>		23B. DATE SIGNED <b>3/31/1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Adnan M. Sonmez</b>
23D. ADDRESS <b>1011 Frederick Rd. Bal. Md. 21228</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>4-3-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Balto. Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Phyllis E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>



# FUNERAL DIRECTOR: IMPORTANT

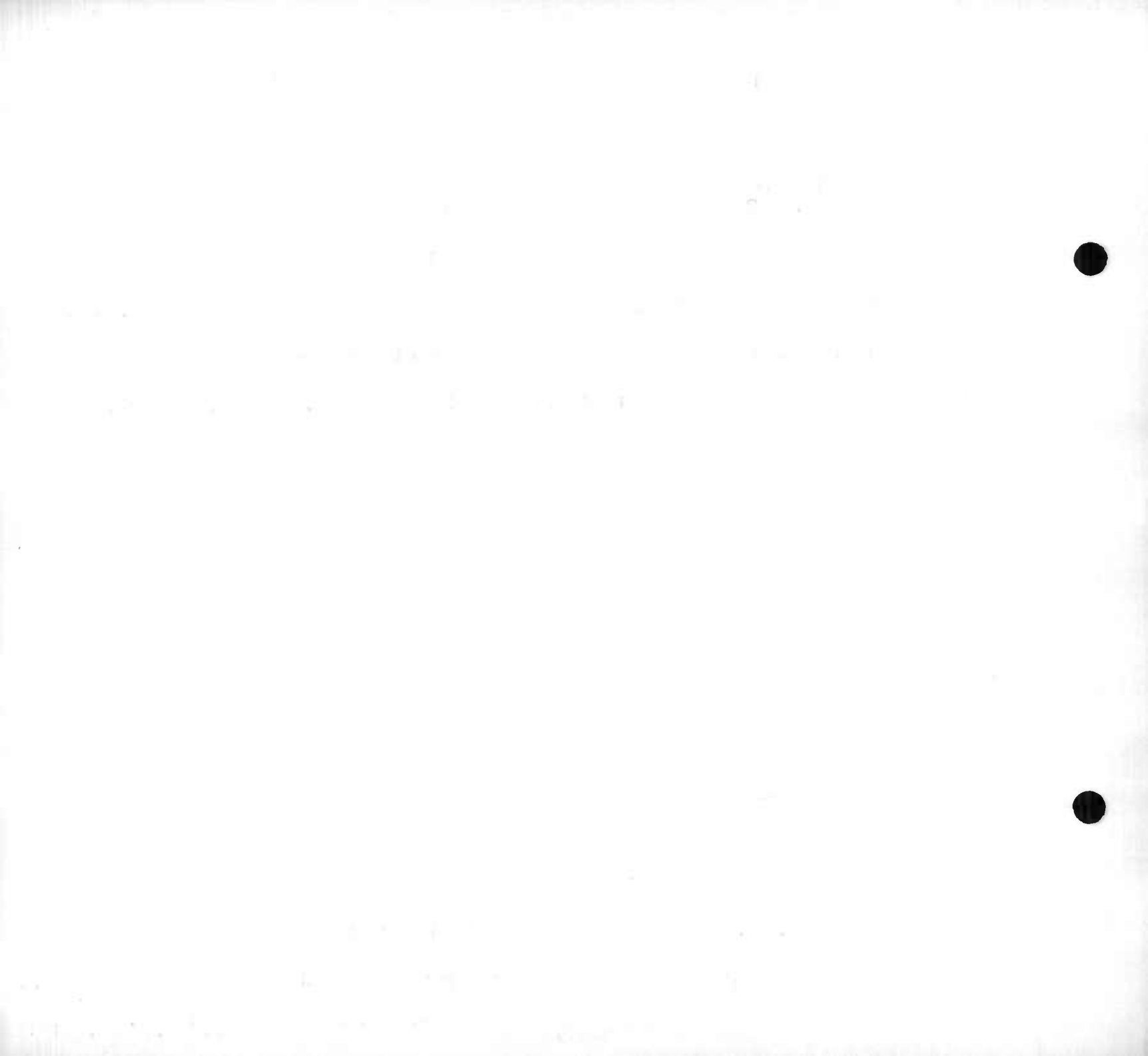
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3439</u>	
BIRTH NO. <u>70 3439</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Emilie Hantzperg</u>		2. DATE AND HOUR OF DEATH <u>3-28-70</u> <u>9:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>11-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>905 St. Paul St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1881</u>	9. AGE (In years lost birthday) <u>88</u>	10. Under 1 Yr. Months <u>11</u> Days <u>01</u> Hours <u>01</u> Min. <u>01</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - PRIVATE GOVERNESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (State or foreign country) <u>GIROMAGNY, FRANCE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Hantzperg</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Pauot</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>182-26-7917</u>		17. INFORMANT <u>ROBERT KRIGER, 905 ST. PAUL ST.</u>	
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac embolism</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u>		<u>1 wk</u>	
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u>				<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>3/21</u> 19 <u>70</u> to <u>3/28</u> 19 <u>70</u> that <u>we</u> last saw the deceased alive on <u>3/28</u> 19 <u>70</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barbado, M.D.</u>		23B. DATE SIGNED <u>3/29/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>BARBADO, M.D.</u>		23D. ADDRESS <u>MERCY HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/3/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
24D. LOCATION <u>Baltimore County</u>		<u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1970</u>		25B. NAME OF REGISTRAR <u>W. E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co., 4905 York Road, Balto., Md. 21212</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

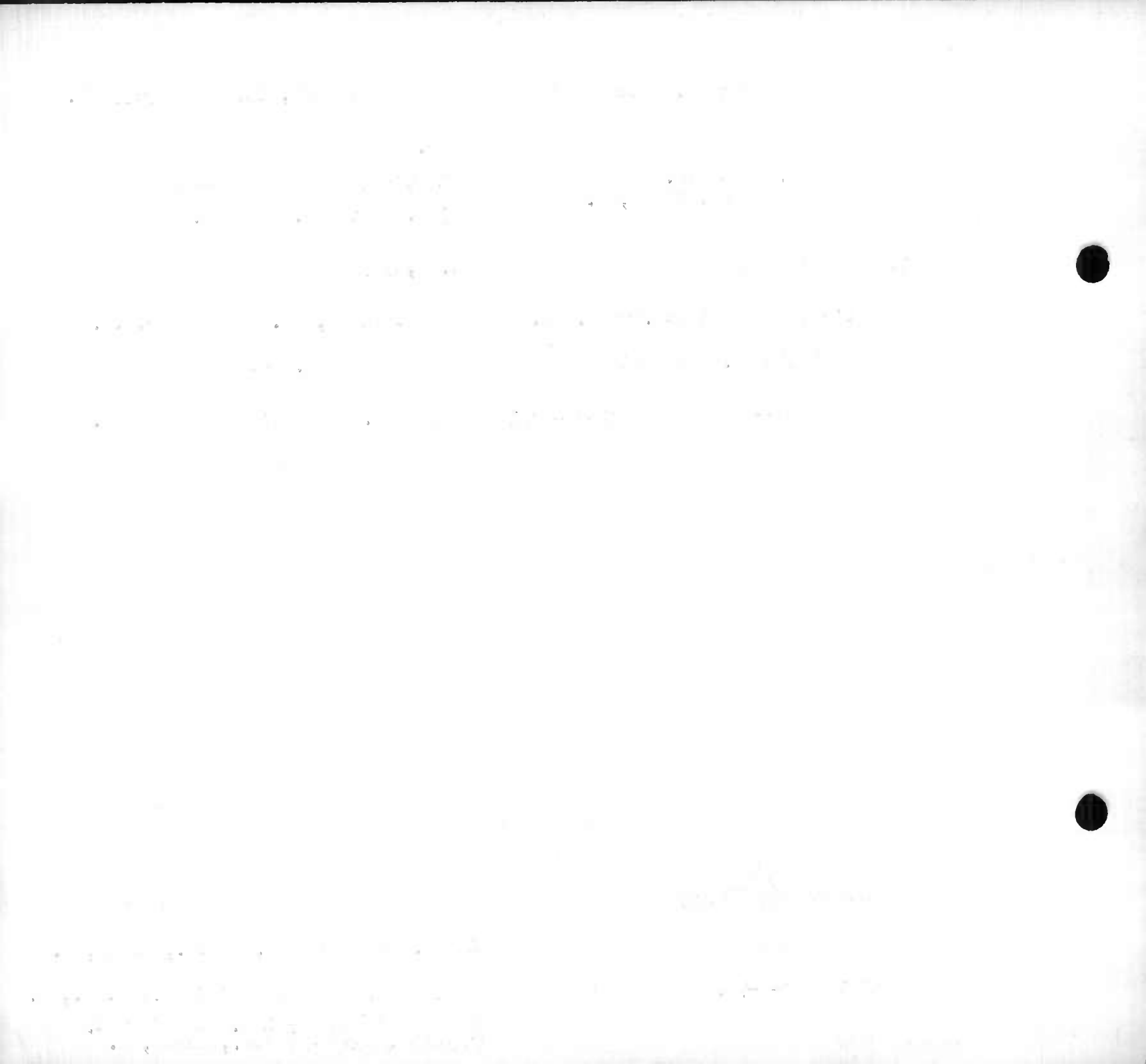
BALTIMORE CITY HEALTH DEPARTMENT				70 3440		REG. NO. 70 3440	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Maria Barth Wooden				2. DATE AND HOUR OF DEATH March 31, 1970 12:34 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1511 Pentridge Road Apt. 262				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-49 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1511 Pentridge Road			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1886	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Barth			14. MOTHER'S MAIDEN NAME Pauline Holzapfel				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-18-7183		17. INFORMANT ADDRESS Miss Maria B. Wooden New York 10595		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease B. DUE TO, OR AS A CONSEQUENCE OF: C. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 10 yrs							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from January 1970 to March 31 1970 that (1) (we) last saw the deceased alive on March 25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. A. Allan Spier				23B. DATE SIGNED 3/31/70		23C. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-1970		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Road Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3441</u>
11-252 70 3441		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BERNARD J. MacKENZIE</b>		2. DATE AND HOUR OF DEATH <b>March 28, 1970 9:35 P.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3 S. East Ave. Baltimore, 21224, Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-10</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3 S. East Ave. # 21224.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1905</b> 9. AGE (in years last birthday) <b>64</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Trans. Co.</b>		11. BIRTHPLACE (State or foreign, country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. MacKenzie</b>		
14. MOTHER'S MAIDEN NAME <b>Mary E. Ruth</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213-05-9071</b>		17. INFORMANT <b>Eunice M. MacKenzie</b> ADDRESS <b>Same.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>153.9 I</b> <b>Cancer of Intestine</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Cancer of Intestine</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 1</b> 19 <b>77</b> to <b>MARCH 28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>MARCH 26</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Benjamin Highstein</b>		23B. DATE SIGNED <b>4/1/70</b>		23C. PHYSICIAN'S NAME (Type) <b>BENJAMIN HIGHSTEIN</b>
23D. ADDRESS <b>121 S. Highland Ave. Balto., 21224, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>4-1-70.</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba. Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Miller, Balto., 21224, Md.</b>





**FUNERAL DIRECTOR: IMPORTANT**

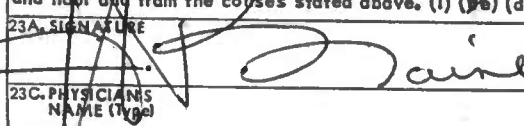
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

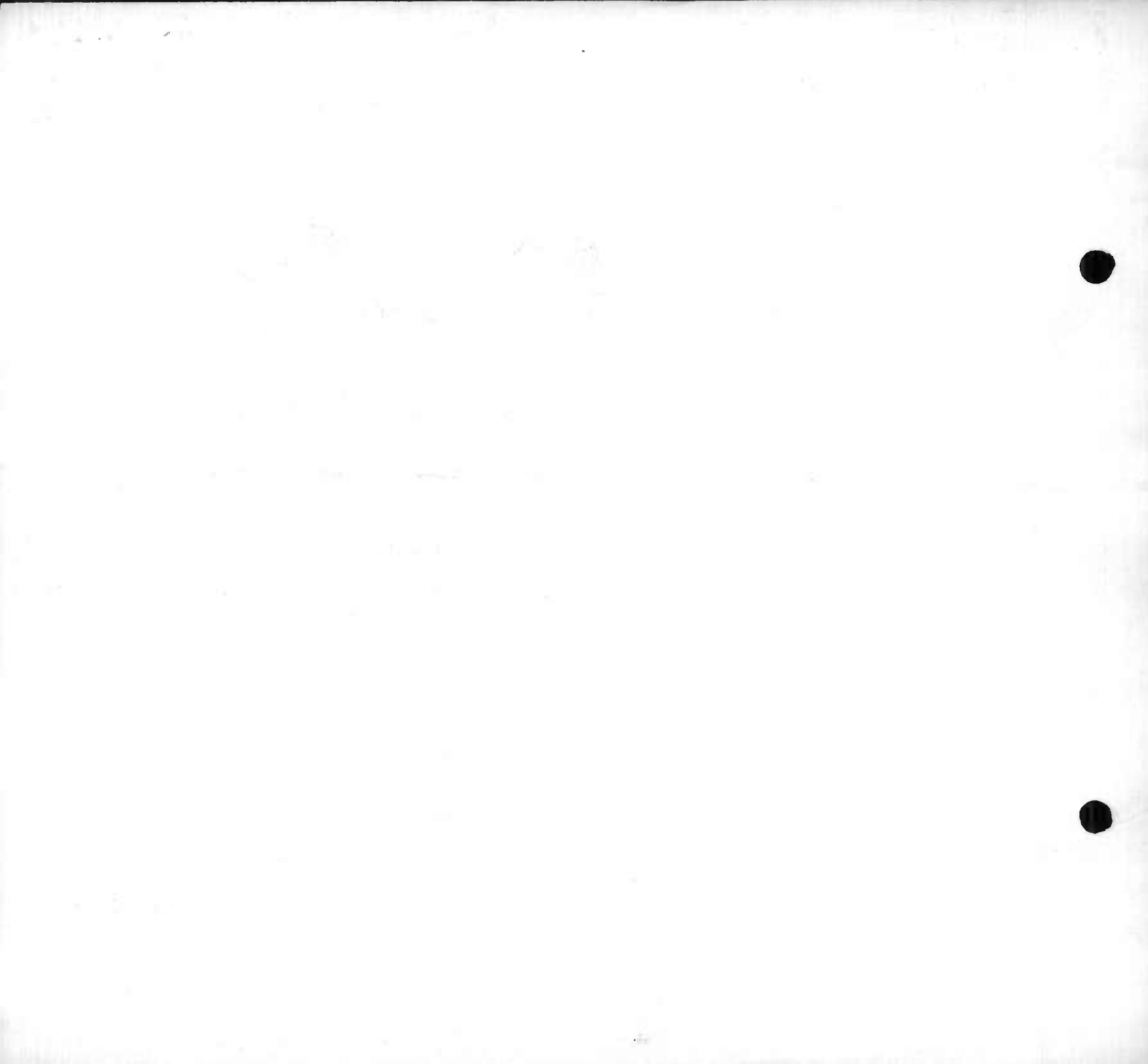
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3442</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">C-455 70 3442</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LUCY COLEMAN</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/28/70 10:28 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">VA.</span> B. COUNTY <span style="font-size: 1.2em;">V-43</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">USPHS HOSPITAL BALTIMORE</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">ALEXANDRIA</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <span style="font-size: 1.2em;">Apt #3 1208 N. PITT.</span>		
5. SEX <span style="font-size: 1.2em;">FEM</span>	6. RACE <span style="font-size: 1.2em;">CAUC</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/7/10</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">60</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VA.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">FRANK SIMMS</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">LENA RODGERS</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Thomas L. Coleman Alex., Va.</span>			
18. <span style="font-size: 1.2em;">180X+1320.9</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">BACTERIAL MENINGITIS</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">PNEUMONOPHARITIS</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CERVICAL CANCER</span> (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">DAYS</span> <span style="font-size: 1.2em;">WEEKS</span> <span style="font-size: 1.2em;">YEARS</span>		
<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/17</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/28</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Donald E. Beaudoin MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3/29/70</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/1/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Comfort</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Fairfax Co. Virginia</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 1 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">P. E. E. Taylor MD</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Cunningham Funeral Home, Inc. Alex., Va.</span>			



# FUNERAL DIRECTOR: IMPORTANT

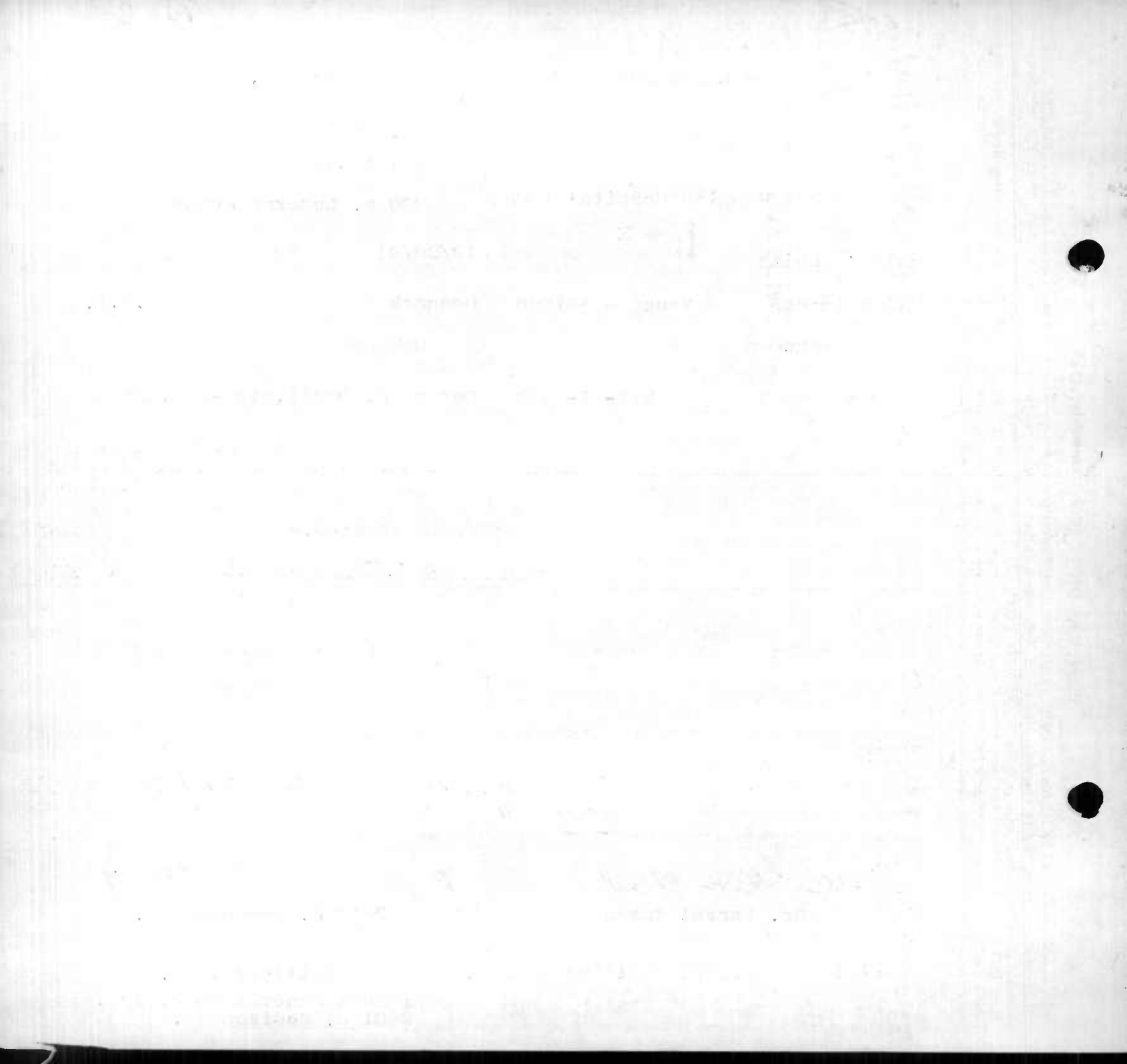
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000 70 3443		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 22702 3443 RS LEE, JACK
1. NAME OF DECEASED (Type or Print) <b>JACK LEE</b>		2. DATE AND HOUR OF DEATH <b>3/28/70 8:45 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before if foreign)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 J. H. Hosp</b>		A. STATE <b>MD</b> B. COUNTY <b>1002</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>701 N. Central Ave</b>		
5. SEX <b>M.</b>	6. RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/98</b>	9. AGE (in years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-8917</b>		17. INFORMANT <b>ella Jones 701 N. Central Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Resp Arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C.O.P.D.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of Prostate</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mi</b> <b>10 years</b> <b>1 year</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (M) (this hospital) attended the deceased from <b>June 1969 to 3/28 1970</b> that (I) (we) last saw the deceased alive on <b>3/28 1970</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>3/28/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. J. J. Dine</b>
23D. ADDRESS		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>
24D. LOCATION (City, town, or county) (State) <b>D. D. County, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph B. Lock, Jr. 1304 N. Central Ave</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

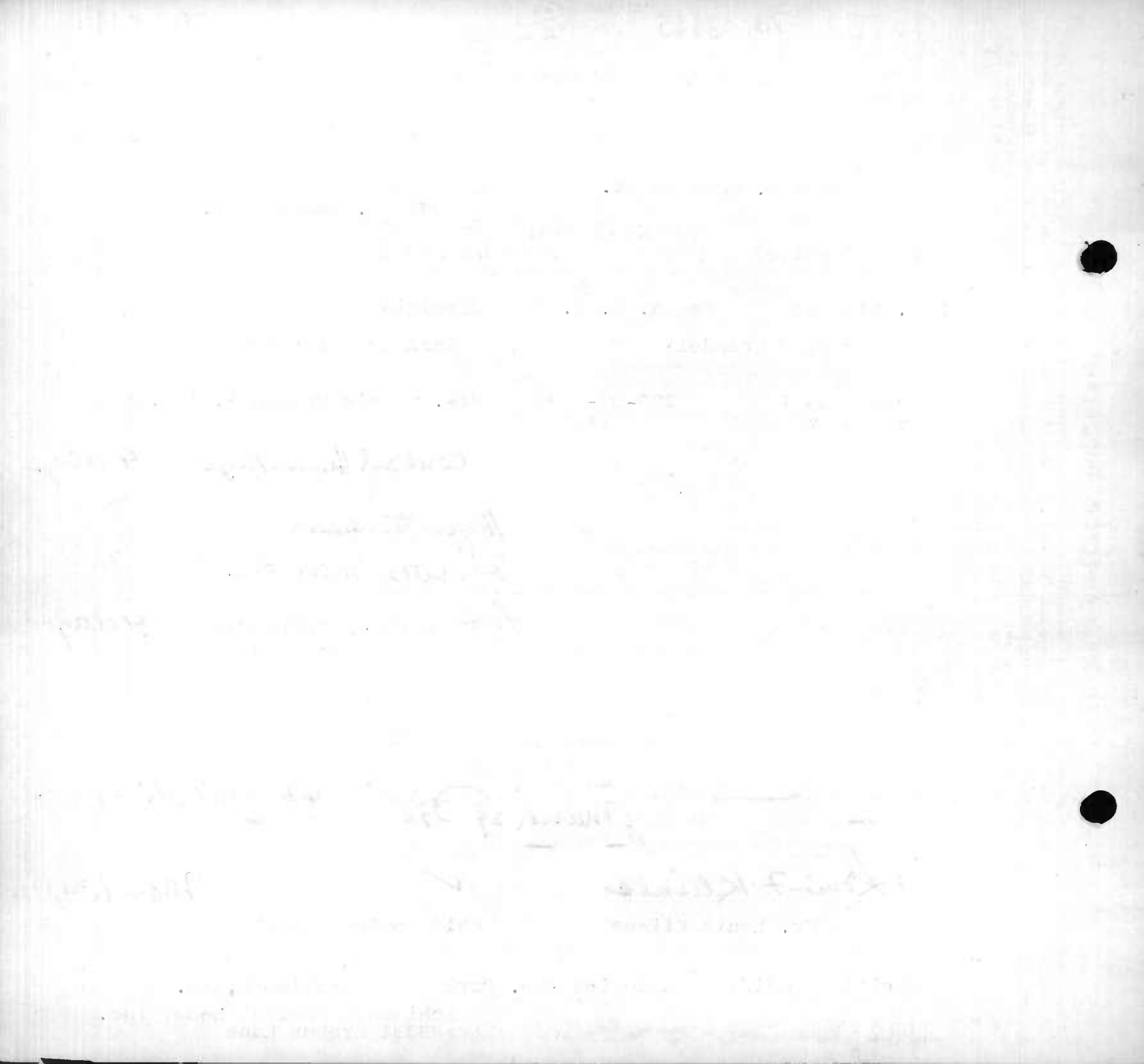
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3444</span>	
<p>1-525</p> <p>BIRTH NO. <span style="float: right;">70 3444</span></p> <p>1. NAME OF DECEASED (Type or Print) <b>SAMUEL JOHNSON</b></p>		<p>2. DATE AND HOUR OF DEATH <b>March 29, 1970</b></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>33 99 Johns Hopkins Hospital (DOA)</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <b>Md.</b> B. COUNTY <b>21205</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>900 N. Luzerne Avenue</b></p>			
<p>5. SEX <b>male</b></p>	<p>6. RACE <b>white</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>12/20/91</b></p>	<p>9. AGE (In years last birthday) <b>78</b></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Young &amp; Seldon</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Denmark</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		<p>13. FATHER'S NAME <b>unknown</b></p>			
<p>14. MOTHER'S MAIDEN NAME <b>unknown</b></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 1 217-01-2913</b></p>			
<p>16. SOCIAL SECURITY NO. <b>217-01-2913</b></p>		<p>17. INFORMANT ADDRESS <b>Gerard A. Droll, step-son, above</b></p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.3 I Anterior wall heart disease -&gt; 1 year</b> <b>Acute congestive failure</b> <b>Heb. bron.</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Ischemia</b> <b>7 years</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized arteriosclerosis</b> <b>18 years</b></p>			
II					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <b>March 28 1956</b> to <b>March 29 1970</b>, that (I) (we) lost saw the deceased alive on <b>Dec. 11 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Israel Rosen M.D.</b></p>		<p>23B. DATE SIGNED <b>3/31/69</b></p>		<p>23C. PHYSICIAN'S NAME (Type) <b>Dr. Israel Rosen</b></p>	
<p>23D. ADDRESS <b>2413 E. Monument St.</b></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>			
<p>24B. DATE <b>3/31/70</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b></p>		<p>25B. NAME OF REGISTRAR <b>Edith E. Johnson</b></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601 E. Madison St.</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3445</span>	
C-653 70 3445		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
JOHN (JACK) GLOVER CRANDELL		3/29/70 <span style="float: right;">2<sup>30</sup> P. M.</span>		701	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
Md. 21205		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		8. STREET AND NUMBER			
2811 E. Madison St.		2811 E. Madison St.			
9. SEX	10. RACE	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	12. DATE OF BIRTH	13. AGE (In years last birthday)	14. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/30/70	74	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country)	
Ret. Watchman		Penna. R. R.		Virginia	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. CITIZEN OF WHAT COUNTRY?	
Wesley Crandell		Rosa Lee Williams			
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. SOCIAL SECURITY NO.		23. INFORMANT ADDRESS	
yes WW 1		220-03-8195		Mrs. Ruzzie Crandell, wife, above	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		25. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II		Cerebral Hemorrhage		4 days	
ANTECEDENT CAUSES		Hypertension		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Diabetes Mellitus		?	
27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Left sided paralysis		4 days	
28. DATE OF OPERATION	29. CONDITION FOR WHICH OPERATION WAS PERFORMED	30. AUTOPSY? (Yes or No)		31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
32. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	33. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	34. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
35. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	36. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	37. 21F. HOW DID INJURY OCCUR?			
38. I certify that (I) (this hospital) attended the deceased from <u>Jan 1943</u> to <u>March 29 1970</u> , that (I) (we) last saw the deceased alive on <u>March 29 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
39. 23A. SIGNATURE		40. 23B. DATE SIGNED			
Louis F. Klimes		March 31, 1970			
41. 23C. PHYSICIAN'S NAME (Type)		42. 23D. ADDRESS			
Dr. Louis Klimes		4814 Bowleys Lane			
43. 24A. BURIAL CREMATION, REMOVAL (Specify)	44. 24B. DATE	45. 24C. NAME of CEMETERY or CREMATORY	46. 24D. LOCATION (City, town, or county) (State)		
Burial	4/1/70	Lakeview Mem. Park	Baltimore, Md.		
47. 25A. DATE REC'D BY HEALTH DEPT.	48. 25B. NAME OF REGISTRAR	49. 25C. FUNERAL DIRECTOR		50. ADDRESS	
APR 2 1970	Schimunek Funeral Home, Inc.	3331 Bröhms Lane			





70 3446

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
JOHN LIGHT							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
00 4738 Chatford Avenue		March 28, 1970					9:20 P.
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2642	
10. DATE OF BIRTH 9/20/09		11. AGE (In years last birthday) 60		12. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		13. CITY OR TOWN Baltimore	
14. BIRTHPLACE (State or foreign country) Penna.		15. CITIZEN OF WHAT COUNTRY?		16. STREET AND NUMBER 4738 Chatford Avenue		17. FATHER'S NAME William Light	
18. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Examiner		19. KIND OF BUSINESS OR INDUSTRY Title Guarantee		20. MOTHER'S MAIDEN NAME Jennie Smith		21. INFORMANT Finksburg, Md. ADDRESS 21048 Clarence E. Pond, Rt. 7, Box 143	
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean War		23. SOCIAL SECURITY NO. 217-14-2018		24. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		28. DATE OF OPERATION 4/1/70		29. CONDITION FOR WHICH OPERATION WAS PERFORMED	
30. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		33. AUTOPSY? (Yes or No) No	
34. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		36. HOW DID INJURY OCCUR?		37. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
38. ACTUAL SIGNATURE Charles S. Springate, M.D.		39. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		40. DATE SIGNED March 29, 1970		41. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
42. DATE 4/1/70		43. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		44. LOCATION (City, town, or county) (State) Arlington, Va.		45. 25A. DATE RECEIVED BY HEALTH DEPT. APR 2 1970	
46. NAME OF REGISTRAR Robert E. Taylor, M.D.		47. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		48. ADDRESS		49. 25B. NAME OF REGISTRAR	

77

17th Street, New York

Office of the Mayor

10-10-10

City of New York

Department of Health

Sanitary Department

For the purpose of the

Sanitary Department

Sanitary Department

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Sanitary Department

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3447</u>	
<div style="display: flex; justify-content: space-between;"> <span>E-560 70 3447</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
M. <u>IDA EMERY</u>		03-28-70		1:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>701</u>		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
<u>BALTIMORE</u>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
<u>500 N. CURLEY STREET</u>					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months Days
<u>FEMALE</u>	<u>WHITE</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>1905</u> <u>03-05-18</u>	<u>65</u>	11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
<u>Charwoman Eastway Bowling Lanes</u>			<u>Baltimore, Md.</u>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<u>Ritzel</u>			<u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		<u>215-01-7186</u>		<u>Nelson Emery 500 N. Curley St.</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>BLEEDING VARICES AND MITRAL</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>INSUFFICIENCY</u>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>3/13/70</u>		<u>VARICES</u>		<u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>3/12</u> 19 <u>70</u> to <u>3/28</u> 19 <u>70</u> that (H) (we) last saw the deceased alive on <u>3/28/1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Lloyd W. Jacobs</u>				<u>3/28/70</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>LLOYD W. JACOBS</u>		<u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>4/1/70</u>		<u>Holy Redeemer Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>APR 2 1970</u>		<u>Robert E. Jacobs, MD</u>		<u>3331 Bedlam Lane</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Edward WILLIAM WILSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 28, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 28, 1970</b>		Hour <b>10:45 P.M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2102</b>				
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>4/14/09</b>		10. AGE (In years last birthday) <b>60</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>1364 Washington Boulevard</b>
13. FATHER'S NAME <b>Jacob Wilson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooper</b>		
14B. KIND OF BUSINESS OR INDUSTRY <b>Cross &amp; Blackwell</b>		15. MOTHER'S MAIDEN NAME <b>unknown</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>220-10-2363</b>		18. INFORMANT <b>2127 Cockspur Rd Marchell E. Wilson, son</b>
19. <b>441.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive retroperitoneal hemorrhage</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ruptured abdominal aortic aneurysm</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 29, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3449		Registered No. 70 3449	
<b>BIRTH NO.</b> W-514 70 3449 <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> August (Type or Print) <b>Albert WINFELDER</b>				<b>2. DATE AND HOUR OF DEATH</b> 3/27/70 11 A.M.			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) 90 MIDTOWN HOME, INC. 808 St. Paul Street Baltimore, Md				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> Md <b>B. COUNTY</b> 702 <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) Baltimore <b>D. STREET ADDRESS</b> (If rural, give location) 2714 E. Jefferson Street			
<b>5. SEX</b> M	<b>6. RACE</b> W	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) M	<b>8. DATE OF BIRTH</b> 4/10/01	<b>9. AGE</b> (In years last birthday) 68	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Stevedore	<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Terminal Warehouse	<b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Md.
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> George Winfelter			
<b>14. MOTHER'S MAIDEN NAME</b> Barbara Krueger				<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) no			
<b>16. SOCIAL SECURITY NO.</b> 219-03-4591				<b>17. INFORMANT</b> Dorothy Winfelter, wife, above			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) DUE TO Cardiovascular failure massive Cerebral Hemorrhage (B) DUE TO Anterior Cerebral Artery (C) Parkinson's Disease			
<b>INTERVAL BETWEEN ONSET AND DEATH</b>				<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from July 23, 1969, to Mar 27, 1970 that (I) (we) lost saw the deceased alive on Mar 27, 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> [Signature] M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				<b>23B. DATE SIGNED</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) William D Appleford M.D.				<b>23D. ADDRESS</b> 6615 Newkirk Rd			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> 3/31/70		<b>24C. NAME of CEMETERY or CREMATORY</b> Sacred Heart of Jesus Cem.		<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Md.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> APR 2 1970		<b>25B. NAME OF REGISTRAR</b> Robert E. Taylor, M.D.		<b>25C. FUNERAL DIRECTOR</b> Schimunek Funeral Home, Inc.		<b>ADDRESS</b> 2601 E. Madison St.	

William D. Appleford  
1017 Lexington St.  
Boston, Mass.  
March 1st 1892

Mar 1st 1892

✓  
William D. Appleford  
1017 Lexington St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3450		REG. NO. 70 3450	
BIRTH NO. <b>H-626</b>				70 3450			
1. NAME OF DECEASED (Type or Print) <b>Louis E. Hirschhorn</b>				2. DATE AND HOUR OF DEATH <b>March 31, 1970</b> <b>8<sup>00</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3605 LABYRINTH RD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2720</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3605 Labrynth Rd</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1900</b>		9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Hirschhorn</b>				14. MOTHER'S MAIDEN NAME <b>Same</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>057-10-9856A</b>		17. INFORMANT <b>Mrs. Anne Hirschhorn</b>		ADDRESS <b>Same</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>March 19, 1970</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aspiration</b> 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>			
MEDICAL CERTIFICATION							
22. I certify that (I) (this hospital) attended the deceased from <b>March 1969</b> to <b>March 30, 1970</b> , that (I) (we) lost saw the deceased alive on <b>March 29, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Howard D. Bronstein MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/31/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Howard D. Bronstein, MD</b>				23D. ADDRESS <b>11 E Chase St. Balto Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bnai Israel</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son 9610 Reisterstown Rd</b>			

3605 Labyrinth Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3451</span>	
<div style="font-size: 1.5em; float: left;">H-520</div> <div style="font-size: 1.5em; float: left;">70 3451</div> <div style="clear: both;"></div>				<div style="font-size: 1.5em; float: left;">70 3451</div> <div style="clear: both;"></div>	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				Edward Samuel Hines	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <div style="font-size: 1.2em;">3709 5th Street 21225</div>				March 29, 1970 <span style="float: right;">12<sup>4</sup> A.M.</span>	
				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY	
				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3709 5th Street 21225	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 25, 1894	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Clerk U. S. P. O.			Baltimore, Maryland		U S
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Hines			Pauline Opal		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> W W 1			220-38-7935		Mrs Elsie M. Hines 3709 5th St. 21225
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Acute Comp. / Heart Failure</span>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Arteriosclerotic Cardiovascular</span>		
			(C) <span style="font-size: 1.2em;">Atherosclerosis</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			8 hr  18 months		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from Nov. 16 1968 to MAR 29 1970, that (I) ( <del>was</del> ) lost saw the deceased alive on Feb 1 1970 and that in (my) ( <del>an</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<span style="font-size: 1.2em;">B.S. Karpers Jr.</span>				<span style="font-size: 1.2em;">3/31/70</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
B.S. KARPERS JR. M.D.				514 MEDICAL ARTS BLDG. BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/1/70		Baltimore National	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 2 1970		Robert E. Taylor		McCall F H 237 Patapsco Ave. 21225	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-400 70 3452		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3452	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. JAMES K. NEAL</b>		2. DATE AND HOUR OF DEATH <b>3/29/70 7.55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		C. CITY OR TOWN <b>Catonsville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>6608 Lochinvar Drive</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-09</b>	9. AGE (in years last birthday) <b>60</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assist. Superintendent Balto. Gas &amp; Elec.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>JAMES P. NEAL</b>		14. MOTHER'S MAIDEN NAME <b>MARY Joiner</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. II</b>		16. SOCIAL SECURITY NO. <b>212-05-4214</b>		17. INFORMANT <b>Mr. James K. Neal - 6608 Lochinvar Drive</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Broncho pneumonia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma, left lung 2 years with metastases</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>2</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>70</b> to <b>3/29</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mayuree Khongcharoensuk, M.D.</b>				23B. DATE SIGNED <b>3/29/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAYUREE KHONGCHAROENSUK, M.D.</b>		23D. ADDRESS <b>Bon Secours Hosp. Balto., Md. 21223.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Olivet Park Cem.</b>	
24D. LOCATION <b>Baltimore Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Frederick Cronan</b>		25D. ADDRESS <b>Frederick Cronan 814 Catonsville Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-552 70 3453		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X		REG. NO. 70 3453	
1. NAME OF DECEASED (Type or Print) <b>Mildred Cunningham</b>			2. DATE AND HOUR OF DEATH <b>March 29, 1970 8:00 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3321 Eastern Blvd. 21220</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-15</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>James Hunter</b>			14. MOTHER'S MAIDEN NAME <b>Janet P</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>284-22-3568</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>180X I Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF: II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cancer of Cervix of Uterus</b> DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). III. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>2/29/70</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>3/17/70</b> to <b>3/29/70</b> that (I) (we) last saw the deceased alive on <b>3/29/70</b> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>M. D. Menelas Siouris</b> 23B. DATE SIGNED <b>3/29/70</b> 23C. PHYSICIAN'S NAME (Type) <b>MENELAS SIOURIS M.D.</b> 23D. ADDRESS <b>BCH 4940 Eastern Avenue Baltimore, Maryland 21224</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>4/1/70</b> 24C. NAME of CEMETERY or CREMATORY <b>MT. CARMEL</b> 24D. LOCATION (City, town, or county) (State) <b>BALTO. M.D.</b> 25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b> 25B. NAME OF REGISTRAR <b>Philip E. Fisher, M.D.</b> 25C. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b> ADDRESS <b>300 MACE</b>					

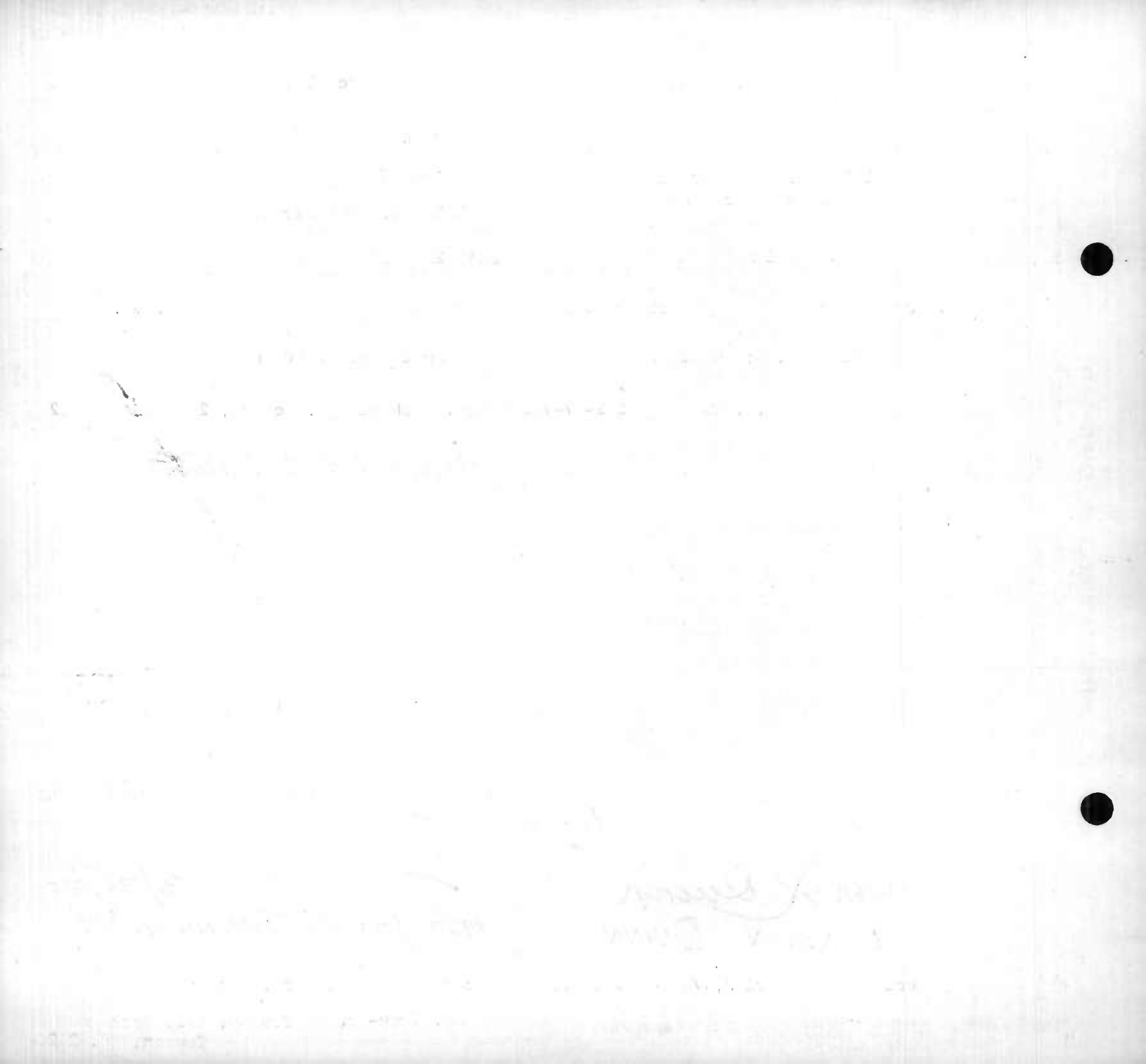




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3454</span>	
<div style="font-size: 2em; float: left;">0-241</div> <div style="font-size: 2em; float: right;">70 3454</div> <div style="clear: both;"></div>		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DENNIS E. O'SULLIVAN		March 29, 1970 <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  2725 St. Paul Street 00 Baltimore, Maryland			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2725 St. Paul Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 29, 1911	58	Clerk
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Clerk		Baltimore Co.	Maryland	U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Daniel V. O; Sullivan			Julia A. Reardon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		W.W. Two	Mrs. Catherine C. Eckert, 28 Belfast Rd, 21093		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 11<sup>th</sup></i> 1963 to <i>March 29<sup>th</sup></i> 1970, that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 18<sup>th</sup></i> 1970 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>M. X. Quinn</i>				<i>3/30/70</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. KEVIN QUINN				1927 York Rd, TIMONIUM, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		April 1, 70		New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 2 1970		Robert E. Farley, M.D.		Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

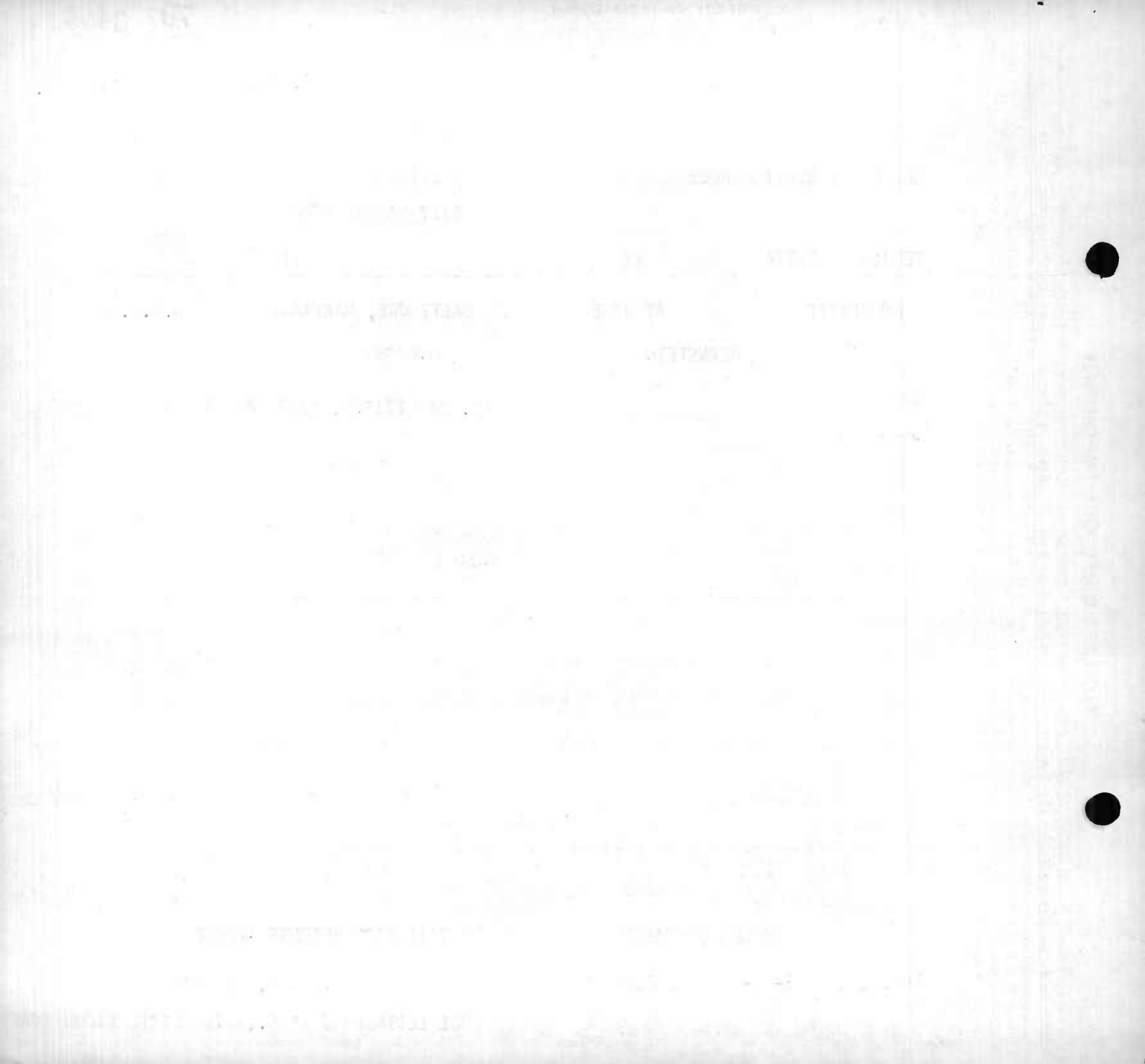
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3455</span>	
<div style="display: flex; justify-content: space-between; align-items: center;"> <span style="font-size: 1.5em;">S-536</span> <span style="font-size: 1.5em;">70 3455</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BESSIE SNYDER		MARCH 30, 1970 2:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  PLEASANT MANOR NURSING HOME 90			MARYLAND		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2500 W. BELVEDERE AVENUE					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
FEMALE	WHITE			85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUSSIA	
12. CITIZEN OF WHAT COUNTRY?			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
NATHAN NECHAMKIN			SARAH NECHAMKIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NO		MR. ISAAC GOLD, 6504 GARDENWICK RD. #21209	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p><b>CAUSE OF DEATH</b></p> <p>CARCINOMA - METASTATIC SUPRA-PUBLIC</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> </div> <div style="width: 10%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 yr.</p> </div> </div>					
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>ANTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 1969 to 3/29 1970, that (I) (we) lost saw the deceased alive on 3/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				3/30/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH BLUM				1115 N. CALVERT STREET	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3-31-70		ANSHE NEISIN	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ZIP CODE	
ROSEDALE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 2 1970		J. E. Fisher, Reg.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

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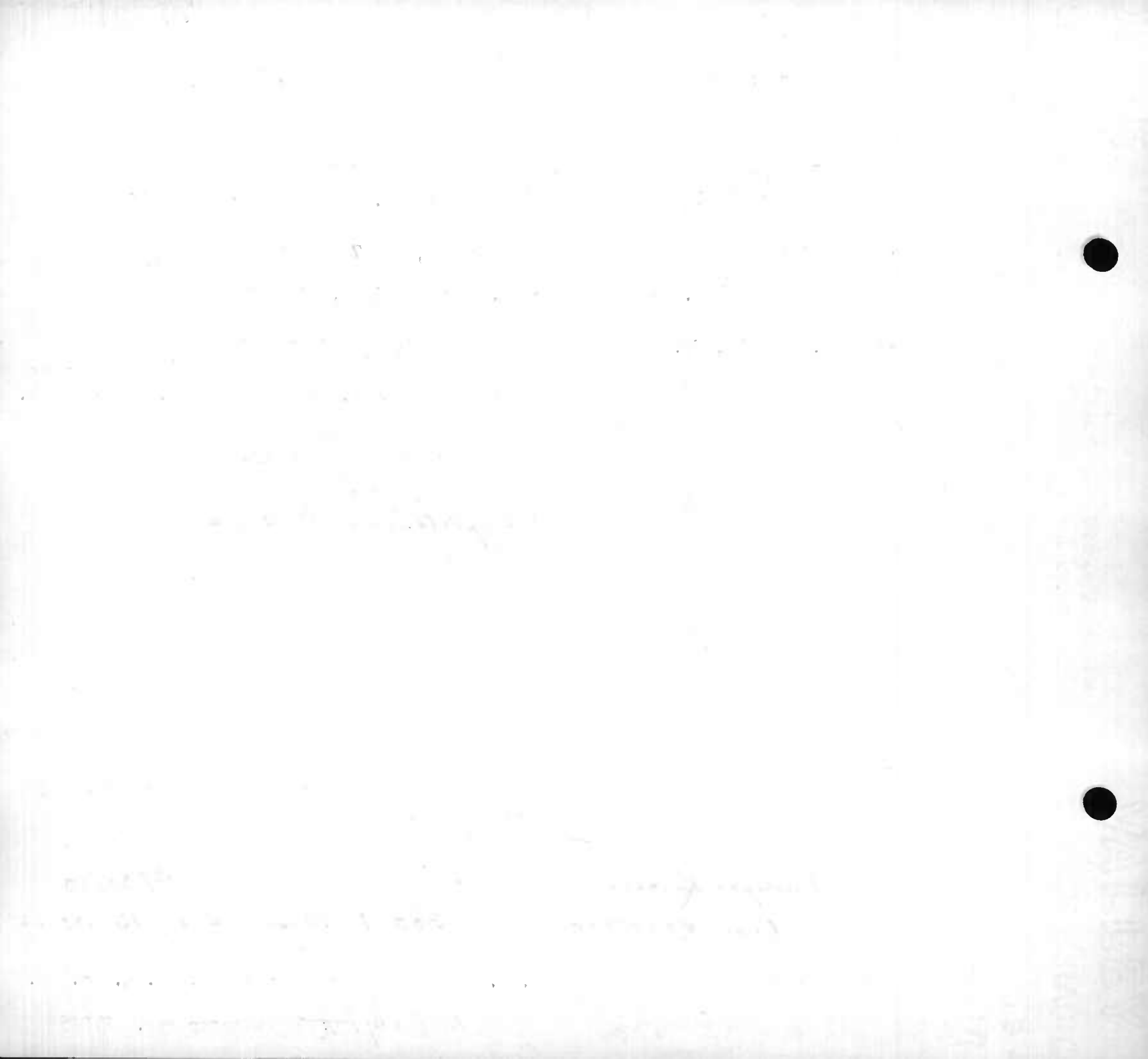
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3456</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">SARA KATZ</span>		<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>MARCH 29, 1970</span> <span>10:05 P. M.</span> </div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">90 BELVEDERE NURSING HOME</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2827 MARNAT ROAD</span>			
<b>5. SEX</b> FEMALE		<b>6. RACE</b> WHITE		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) HOUSEWIFE		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> AT HOME		<b>8. DATE OF BIRTH</b> 81	
<b>13. FATHER'S NAME</b> ? BERNSTEIN		<b>14. MOTHER'S MAIDEN NAME</b> UNKNOWN		<b>9. AGE</b> (In years last birthday) 81	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO		<b>16. SOCIAL SECURITY NO.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>17. INFORMANT</b> MR. SAM TILSON, 2837 MARNAT ROAD #21207		<b>ADDRESS</b>			
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Myocardial Infarction</span>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.5em;">Hypertensive Arteriosclerotic Cardiovascular Disease</span>  <b>(C)</b> <span style="font-size: 1.5em;">Stroke due to Cerebral Arteriosclerosis</span> </div> </div>					
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">minutes</span>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (the hospital) attended the deceased from</b> <span style="font-size: 1.2em;">April 1954</span> <b>to</b> <span style="font-size: 1.2em;">March 29, 1970</span> <b>and that in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">March 28, 1970</span> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">[Signature]</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">March 30, 1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">SAMUEL TOMPAKOV</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">7211 PARK HEIGHTS AVENUE</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) BURIAL		<b>24B. DATE</b> <span style="font-size: 1.2em;">3-31-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">CHIZUK AMUNO</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">APR 2 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		<b>25D. ADDRESS</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3457	
V-514 70 3457		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Royce Venable			2. DATE AND HOUR OF DEATH March 28, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2505		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 99 D O A South Baltimore General Hospital			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3810 St. Margaret Street 21225					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 18, 1907	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper		10B. KIND OF BUSINESS OR INDUSTRY F. Royster Guano Co.		11. BIRTHPLACE (State or foreign country) Warm Springs, Virginia	
12. CITIZEN OF WHAT COUNTRY? U S					
13. FATHER'S NAME George B. Venable, Sr.			14. MOTHER'S MAIDEN NAME Annie McManimay		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 21225 Miss Norma J. Venable 3810 St. Margaret St.	
18. 410.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>mar 18 1970</u> to <u>mar 28 1970</u> , that (I) (we) last saw the deceased alive on <u>mar 28 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip W. Keister			23B. DATE SIGNED 5/30/70		
23C. PHYSICIAN'S NAME (Type) P. W. KEISTER			23D. ADDRESS 302 Patapsco Ave Balto 25		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/70		24C. NAME OF CEMETERY or CREMATORY Glen Haven M. P.	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. A. A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS McCall F. 237 Patapsco Ave. 21225	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-322 70 3458		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>THEODOSIOS, DEMETRIOS</b>		2. DATE AND HOUR OF DEATH <b>3/26/70 15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MD. HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/18/195</b> 9. AGE (in years last birthday) <b>44</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED (COOK)</b>		11. BIRTHPLACE (State or foreign country) <b>TURKEY</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>- RESTAURANT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THEODOSIOS, THEODOSIS</b>		14. MOTHER'S MAIDEN NAME <b>ELENE GIAVASI</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>081-03-1080</b>	
17. INFORMANT <b>T-J. THEODOSIS</b>		ADDRESS <b>above</b>	
18. <b>444.0 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>TARDIAC OCCLUSION OF ABDOMINAL PORTAL</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) <b>ARTERIOSCLEROTIC - V. DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>OLD AGE</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>ASTHMA - Emphysema</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/28 1970</b> to <b>3/26 1970</b> and that (I) (we) lost saw the deceased alive on <b>3/26 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>[Signature]</b> 23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>A-C. KARAS</b> DEGREE		23D. ADDRESS <b>UNIV OF MD HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-28-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>	

4

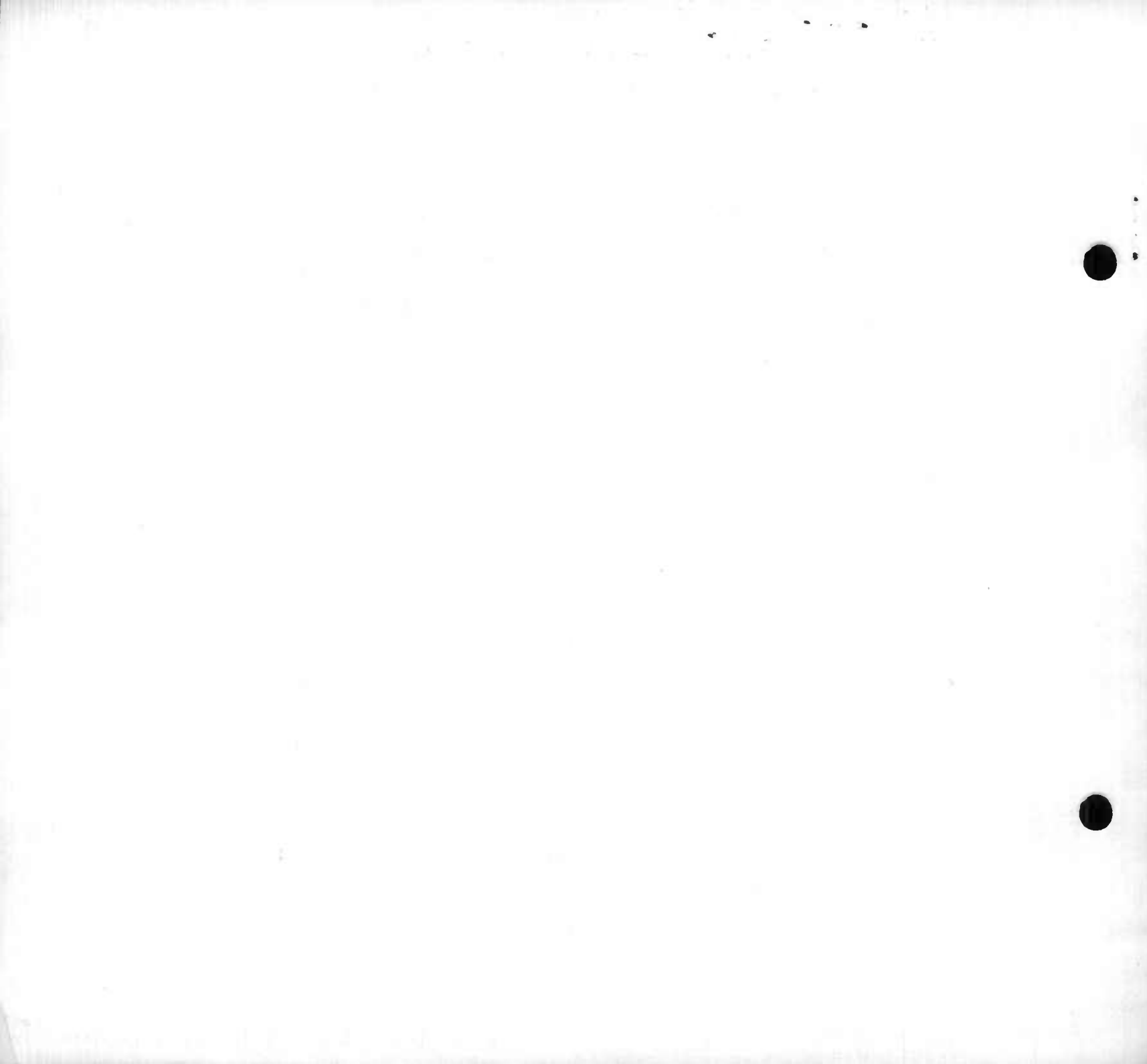
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10. 1. 1968 (10. 1. 1968) 10. 1. 1968  
10. 1. 1968 (10. 1. 1968) 10. 1. 1968

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

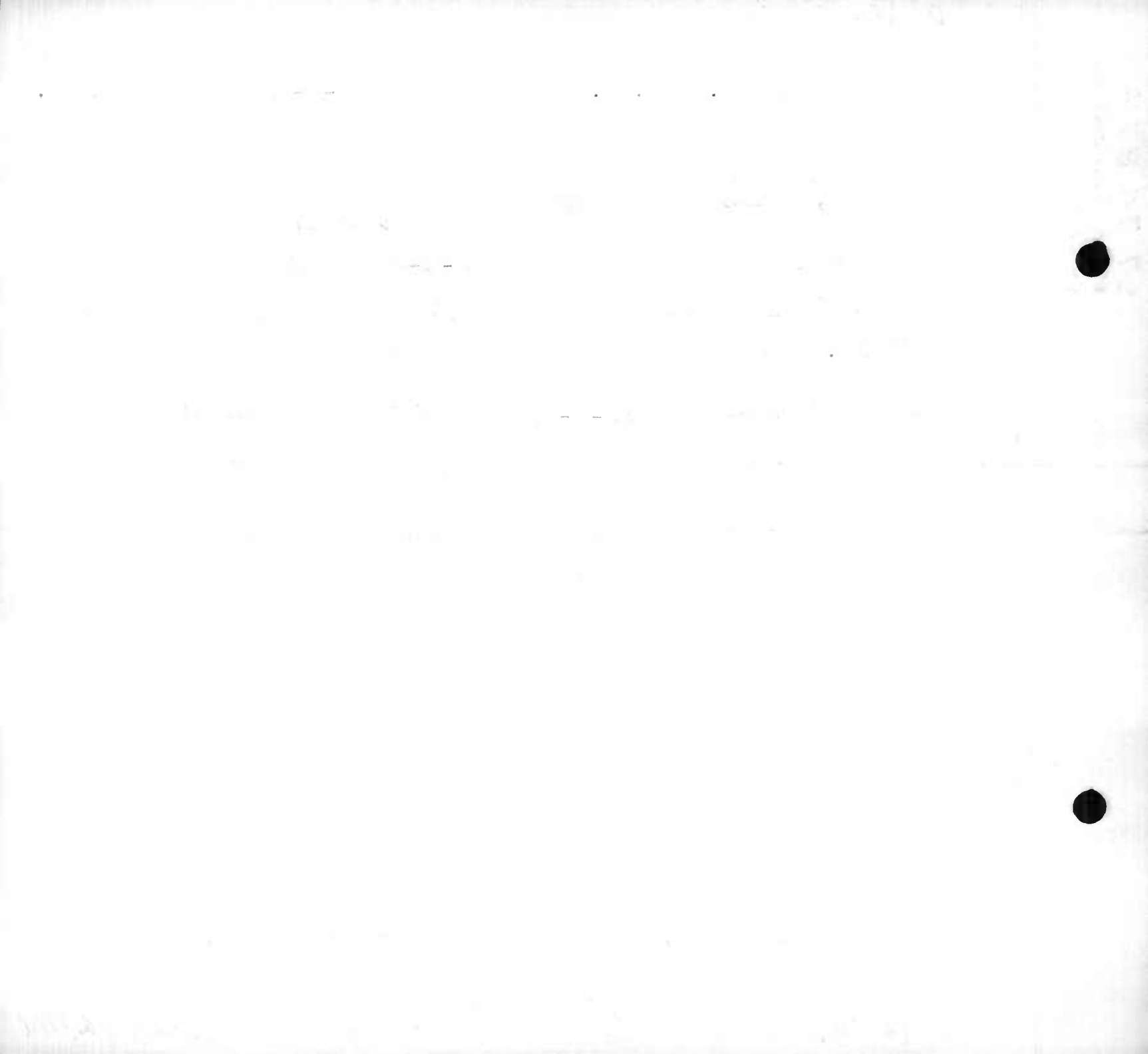
MEDICAL EXAMINER		BALTIMORE CITY HEALTH DEPARTMENT	
70-3459		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 268-3459	
1. NAME OF DECEASED (Type or Print) <b>KATHERINE BOWE. (Catherine)</b>		2. DATE AND HOUR OF DEATH <b>Mar. 30 1970 4-40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1511</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>12 SINAI HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3921 BAROVA ROAD. #15.</b>	
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Board of Education</b>		9. AGE (In years last birthday) <b>51</b>	11. BIRTHPLACE (State or foreign country) <b>Warrenton, N.C.</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John E. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Williams</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If Yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>18-18-4801</b>	
		17. INFORMANT <b>Chart. (Hospital)</b> ADDRESS <b>3921 Barova Rd</b>	
18. <b>625.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, but heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY EMBOLI MULTIPLE.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bleeding extra peritoneal from hysterectomy site.</b> (B) _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hyst. Ligament &amp; Pulmonary embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>3/23/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hyst. Ligament &amp; Pulmonary embolism</b>	
20A. AUTOPSY? (Yes or No) <b>No.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>3/22 1970</b> to <b>3/30 1970</b> . that (I) (we) last saw the deceased alive on <b>3/30 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>D. J. Pradhan</b> M.D.		23B. DATE SIGNED <b>3/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. J. PRADHAN M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/5/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cooks Chapel Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Warrenton, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Morton E. Dyett F.H.</b>	
25C. FUNERAL DIRECTOR <b>1701 Laurens St</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260		70 3460		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3460		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) <b>HENRY H. BAKER, JR.</b>					2. DATE AND HOUR OF DEATH <b>03-29-70 12:30 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL 5200</b>					
					C. CITY OR TOWN <b>ANNAPOLIS</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
					E. STREET AND NUMBER <b>ROUTE #5 BOX 57</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04-21-07</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCIENCE PROFESSOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>TEACHING-SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>HENRY H. BAKER</b>					14. MOTHER'S MAIDEN NAME <b>MAY MCGRANAHAN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>113-09-5039</b>		17. INFORMANT <b>MARGARET T. BAKER # 4</b>				
18. <b>375-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <b>CARDIORESPIRATORY ARREST</b> <b>5 hrs.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>POSSIBLE SEPTIC EMBOLUS TO BRAIN</b> <b>7 hrs.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Aortic valve replacement.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>March 28</b> 19 <b>70</b> to <b>March 29</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>March 29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>William L. Horvath M.D.</b>						23B. DATE SIGNED <b>3/29/70</b>				
23C. PHYSICIAN'S NAME (Type) <b>William L. Horvath, M.D.</b>						23D. ADDRESS <b>The Johns Hopkins Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)		
<b>Burial</b>		<b>4-2-70</b>		<b>Valley Forge Chapel</b>		<b>Valley Forge</b>		<b>Pa.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>			25C. FUNERAL DIRECTOR <b>John M. Lythgoe</b>			ADDRESS <b>Ameyro, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3461	
E-355		70 3461		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hannie E. Dmonds</u>			
2. DATE AND HOUR OF DEATH <u>11:02 3/29/70 11:02 AM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1304</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI Hospital of Balto, Md</u>			
5. SEX <u>F</u> 6. RACE <u>N N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/26/04</u> 9. AGE (in years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Peter TURNER</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Mason</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u> Mrs. Helen Bradford ADDRESS <u>2906 Parkwood Ave</u>	
18. <u>180 X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Metastatic carcinoma of cervix</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Months</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/31/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>intestinal obstruction</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/25/70</u> 19 <u>70</u> to <u>3/29/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/29/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Carl H. Cherry, D.O.</u> DEGREE				23B. DATE SIGNED <u>3/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carl H. Cherry, D.O.</u> DEGREE				23D. ADDRESS <u>SINAI Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton E. Dyett F. H</u> ADDRESS <u>1701 Laurens St.</u>			

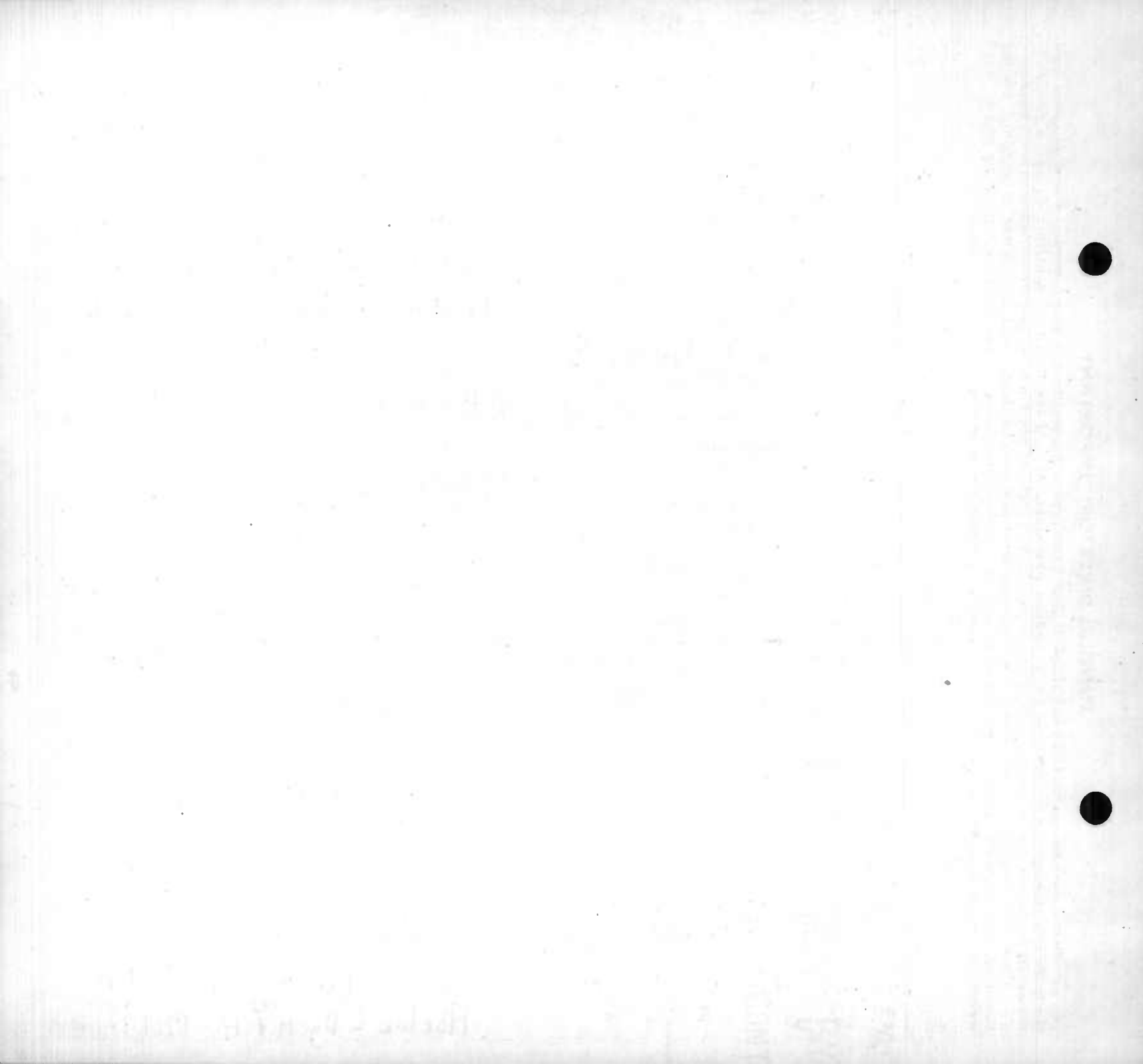




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3462</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Charles T. Lewis, Jr.</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/29/70 1:15</span> <span style="float: right;">P.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">33 Johns Hopkins Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2201</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">216 S. SHARP STREET</span>		
<b>5. SEX</b> <span style="font-size: 1.5em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">N</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">2/14/30</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">40</span>	<b>If Under 1 Yr.</b> Months: _____ Days: _____ <b>If Under 24 Hrs.</b> Hours: _____ Min: _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">County Club</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">U.S.A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles T. Lewis, Sr.</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">GLADYS HOLMES</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO.</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-24-4664</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Gladys Holmes</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cardiorespiratory arrest 2nd to end stage alcoholic liver disease</span> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">YES</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (we) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2/11/70</span> to <span style="font-size: 1.2em;">3/29/70</span>, that (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/29/70</span> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Loren George Lipson, MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/29/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Loren George Lipson, MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">4/3/70</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Mt. Auburn Cem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">APR 2 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Mortg &amp; Dyett F.H.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">1701 Laurens St.</span>			



BIRTH NO.		1. NAME OF DECEASED (Type or Print) DENNIS WILLIAMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 30 70 8:05 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year March 30, 1970 8:05 p.m.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1509	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-9-1948		10. AGE (In years last birthday) 22		E. STREET AND NUMBER 3907 Carlisle Ave.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.		13. FATHER'S NAME French Williams	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Operator		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Louise Haines	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 212-48-2496		18. INFORMANT Mrs. Jacqueline Williams	
				ADDRESS 3907 Carlisle Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Gunshot wound of the chest DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3907 Carlisle Ave. 2nd floor bedroom	
22D. TIME OF INJURY (APPROX.) 3 30 70 7:47p		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self inflicted gunshot wound of chest	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/31/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-70		24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery	
				24D. LOCATION (City, town, or county) (State) Catonsville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
				ADDRESS 1701 Laurens Street	

ACADEMY BOND

FOR OFFICIAL USE

NOV 12

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-236 70 3464		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 3464
1. NAME OF DECEASED (Type or Print) <u>Schuster, Carl Jr.</u>		2. DATE AND HOUR OF DEATH <u>3/23/70</u> <u>8:55p</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Pikesville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>113 Clarendon Ave</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/60</u>	9. AGE (in years last birthday) <u>69</u> 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired physician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Butler - Brothers</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Carl Schuster</u>		
14. MOTHER'S MAIDEN NAME <u>Sophia Horstman</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>None</u>		
16. SOCIAL SECURITY NO. <u>212-10-2992</u>		17. INFORMANT <u>Point of Death, 21777, Md.</u> <u>Mr. Carl H. Schuster Jr. P.O. Box 2</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>years</u>  <u>weeks</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Congestive heart failure</u>				
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <u>3-15</u> 19 <u>70</u> to <u>3-23</u> 19 <u>70</u> that (I) <del>(was)</del> last saw the deceased alive on <u>3-23</u> 19 <u>70</u> and that (in my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>Sam C. Kerr MD</u>		23B. DATE SIGNED <u>3-23-70</u>		23C. PHYSICIAN'S NAME (Type) <u>IAIN C. KERR MD</u>
23D. ADDRESS <u>BON SECOURS HOSP. BALTO #23</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial March 27</u>		
24B. DATE <u>APR 2 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Walter Fisher, 1000 Pikesville Rd</u>



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-243		70 3465		CITY HEALTH DEPARTMENT		REG. NO. 70 3465	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>HELEN K. LESCAZNEY</i>		2. DATE AND HOUR OF DEATH 3-30-70 10:08			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224		A. STATE Maryland		B. COUNTY <i>2758</i>	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5717 Willowton Ave., Balto., Md. 21214			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-07		9. AGE (In years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME <i>ARMSTRONG</i>				14. MOTHER'S MAIDEN NAME <i>KEMP</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Maryland 21224			
18. <i>931.9 + 174X</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE HEPATIC COMA		3 DAYS			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) SERUM HEPATITIS		3 1/2 mo.			
ANTECEDENT CAUSES		(C) CA OF BREAST		1 YEAR			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/30/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY OBST.		20A. AUTOPSY? (Yes or No) YES <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>MAR. 27</i> 19 <i>70</i> to <i>3/30</i> 19 <i>70</i> and that (I) (we) last saw the deceased alive on <i>MAR. 30</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James F. Casellas</i>				23B. DATE SIGNED 3-30-70			
23C. PHYSICIAN'S NAME (Type) JAMES F. CASELLAS				23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville, Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1970		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Delwell Funeral Home, Pikesville, Md.</i>		ADDRESS	

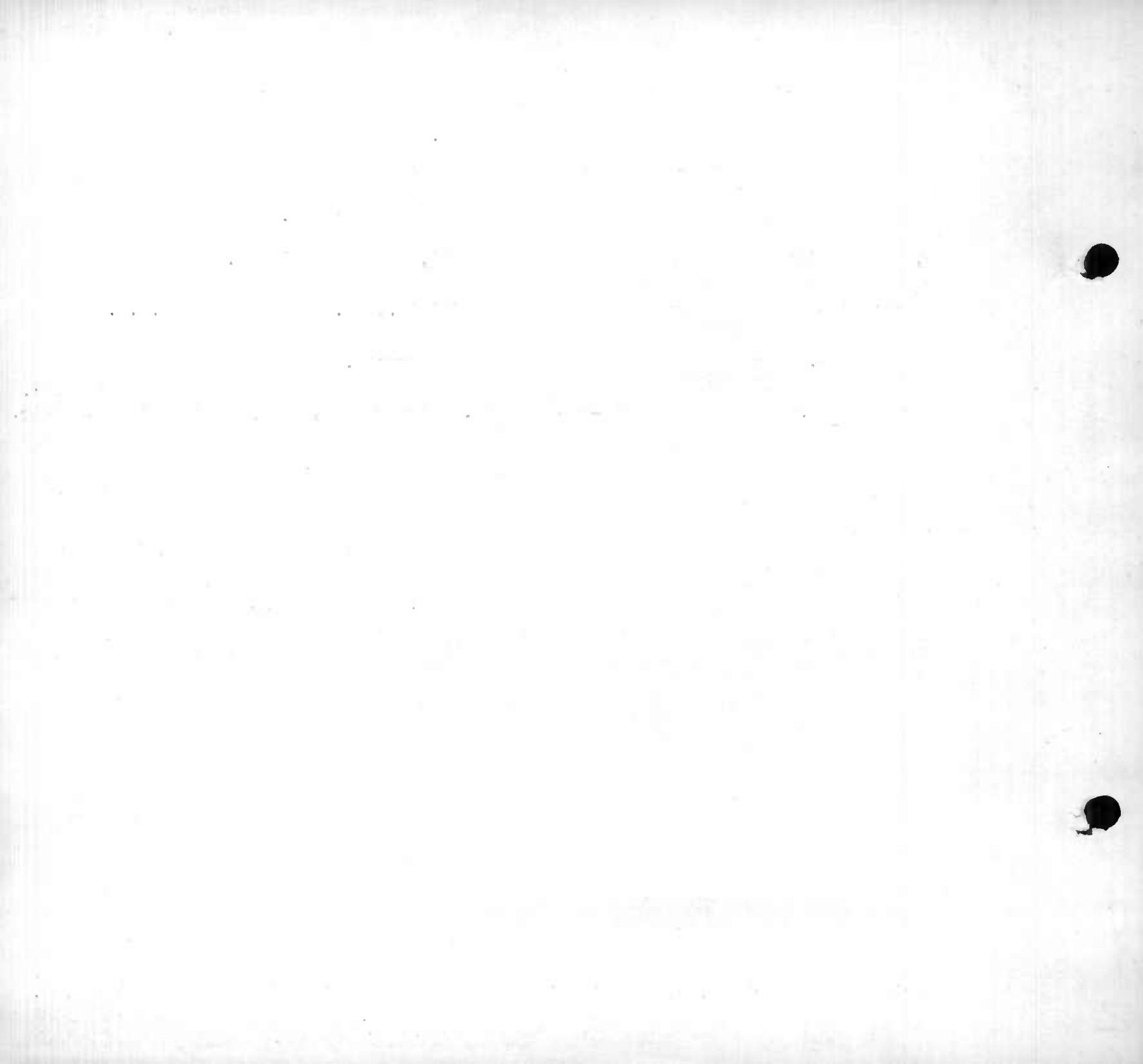
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536 70 3466				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3466	
1. NAME OF DECEASED (Type or Print) <b>SARAH ANN ANDREWS</b>				2. DATE AND HOUR OF DEATH <b>March 26, 1970</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House In The Pines Belvedere</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2788</b>			
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>May 24, 1898</b>		9. AGE (In years last birthday) <b>71 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltio., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John W. Oler</b>			
14. MOTHER'S MAIDEN NAME <b>Anna B. Arndt</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215603-8175</b>				17. INFORMANT <b>Mr. Belvery Long, 3833 Songbird Circle, Baltio.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Breast</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3yr</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ant scl cv disease</b>				10yr			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Maurice Feldman</b>				23B. DATE SIGNED <b>3/26/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Frank H. Jewell, Pikesville</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>March 28, 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION <b>Pikesville</b>				24E. CITY, TOWN, or COUNTY <b>Baltimore, Md.</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frank H. Jewell, Pikesville</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 3467	
H-516 70 3467				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>BERNARD E. HUMPHREY</u>				2. DATE AND HOUR OF DEATH <u>MARCH 30, 1970</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1606</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 CITY HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>809 ROSEDALE AVE.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/1901</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CITY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN J. HUMPHREY</u>			
14. MOTHER'S MAIDEN NAME <u>BARBARA J. DORBERT</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215 05 0905</u>		17. INFORMANT ADDRESS <u>Mrs. Elizabeth M. Humphrey 809 Rosedale Ave.</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>410.9 I</u> <u>Death Myocardial Infarct</u> <u>Arteriosclerotic Heart Disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 3</u> 19 <u>68</u> to <u>Jan 10</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>Jan 10</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sebastian Russo</u>				23B. DATE SIGNED <u>4-2-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO</u>				23D. ADDRESS <u>5017 Harbor Dr.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/3/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>	
24D. LOCATION <u>BALTO., MD.</u>		24E. LOCATION (City, town, or county) (State)			
26A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>		26B. NAME OF REGISTRAR <u>Blaise E. Fisher</u>		26C. FUNERAL DIRECTOR ADDRESS <u>Garth Miller 2334 Jefferson St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-320 70 3468		BALTIMORE CITY HEALTH DEPARTMENT		X 70 3468	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Reese Rhodes</i>		2. DATE AND HOUR OF DEATH <i>3/27/70 10 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hosp. Balto</i>		A. STATE <i>MD</i> B. COUNTY <i>Balto.</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1454 CLARIDGE RD</i>			
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/22/91</i>	9. AGE (in years last birthday) <i>78</i>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Shipyard</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James B. Rhodes</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Reese Rhodes--Baltimore, Md.</i>			
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac failure</i> (B) <i>Arteriosclerotic Heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>chronic</i> (C) <i>Renal Insufficiency</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <i>2/13/70</i> 19 to <i>3/27/70</i> 19 that (it) (we) last saw the deceased alive on <i>3/27/70</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (it) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. McVeny</i>		23B. DATE SIGNED <i>3/27/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. McVeny</i>	
23D. ADDRESS <i>Sinai Hospital--Baltimore</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>March 30</i>		24C. NAME OF CEMETERY or CREMATORY <i>Chesterfield</i>		24D. LOCATION (City, town, or county) (State) <i>Centreville Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Alyce R. Lane Church Hill, Md.</i>	

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S-610 70 3469

BALTIMORE CITY HEALTH DEPARTMENT

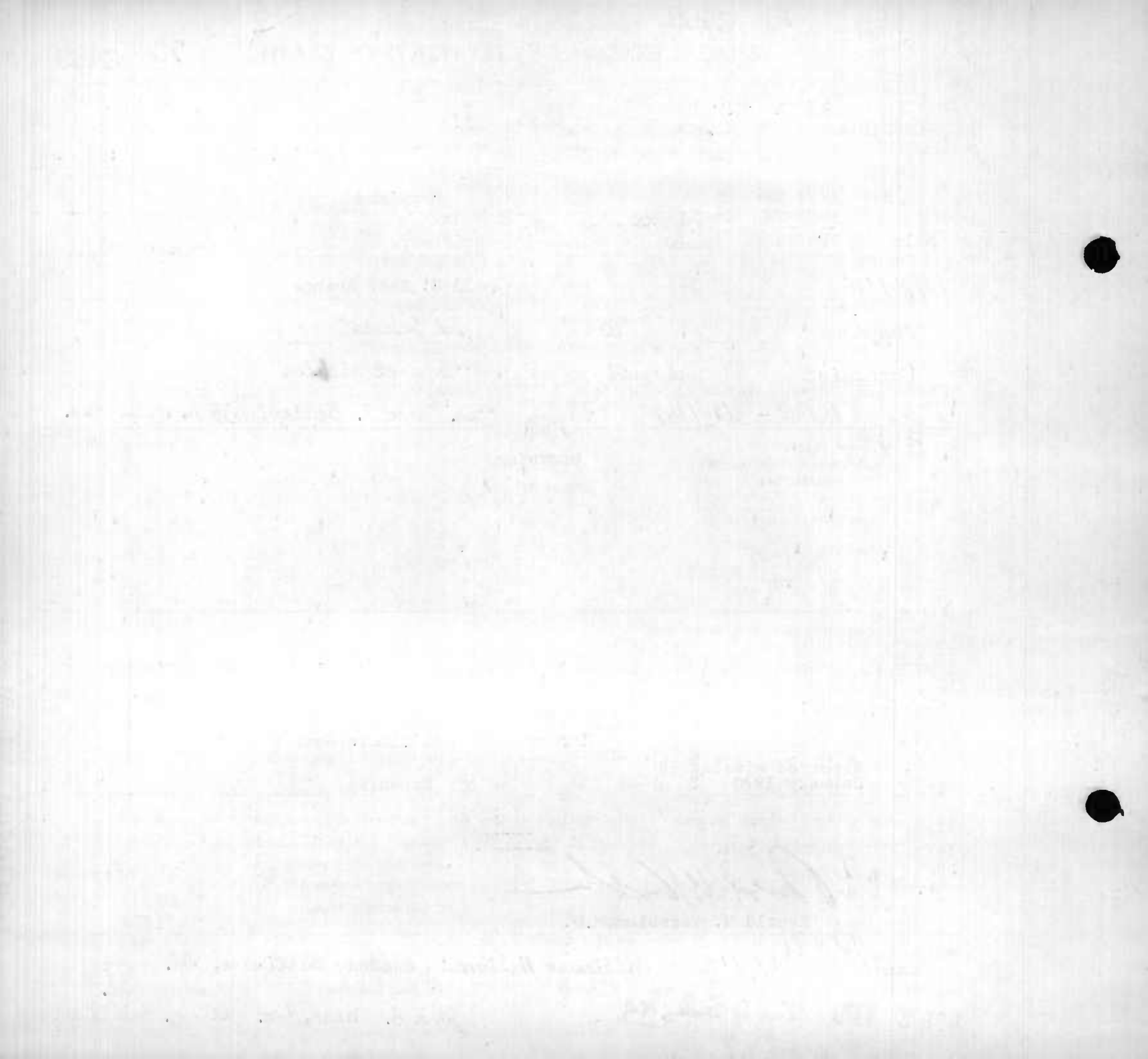
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3469

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EITEL SCHARPF</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 Baltimore Harbor</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 1, 1970 9:00 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12/24/'16</b>		10. AGE (In years, Months, Days, Hours, Min.) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinist</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes 10/46 - 3/15/47</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Carl Scharpf</b>		15. MOTHER'S MAIDEN NAME <b>Margaret Niebler</b>	
18. INFORMANT <b>Mrs. Rose P. Scharpf</b>		ADDRESS <b>435 N. East Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E 954 X I</b>		CAUSE OF DEATH <b>Drowning</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Harbor</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Baltimore Harbor 401</b>		22F. HOW DID INJURY OCCUR? <b>Drowning</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Reported missing 28 January 1970 ? m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>4/1/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery Baltimore, Md.</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970 Robert E. Taylor, M.D.</b>		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>		ADDRESS <b>3000 E. Baltimore St.</b>	

VS 151-REV. 1/1/68





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-152		70 3470		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3470	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Stanley Rubinson					2. DATE AND HOUR OF DEATH April 2, 1970 5:45 PM				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South BALTIMORE General					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DELAWARE B. COUNTY NEW CASTLE C. CITY OR TOWN Newark Delaware D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 106 Haines Street				
5. SEX m		6. RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/28/10		9. AGE (In years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR			10B. KIND OF BUSINESS OR INDUSTRY Hospital			11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Rubinson					14. MOTHER'S MAIDEN NAME ANNA ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Bess Rubinson 106 Haines ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 412.21 CEREBROVASCULAR ACCIDENT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-29-1970 to 4-2-1970 that (I) (We) last saw the deceased alive on 4-2-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William Eric Sohn, M.D.					23B. DATE SIGNED 4-2-70			23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-5-70		24C. NAME OF CEMETERY OR CREMATORY Mt SHARON Cem.			24D. LOCATION (City, town, or county) (State) DELAWARE COUNTY Pa.		
25A. DATE REC'D BY HEALTH DEPT. APR 2 1970			25B. NAME OF REGISTRAR Robert E. Spiby, M.D.			25C. FUNERAL DIRECTOR ADDRESS Leonard A. Brune 1512 N. Broad ST			



# FUNERAL DIRECTOR: IMPORTANT

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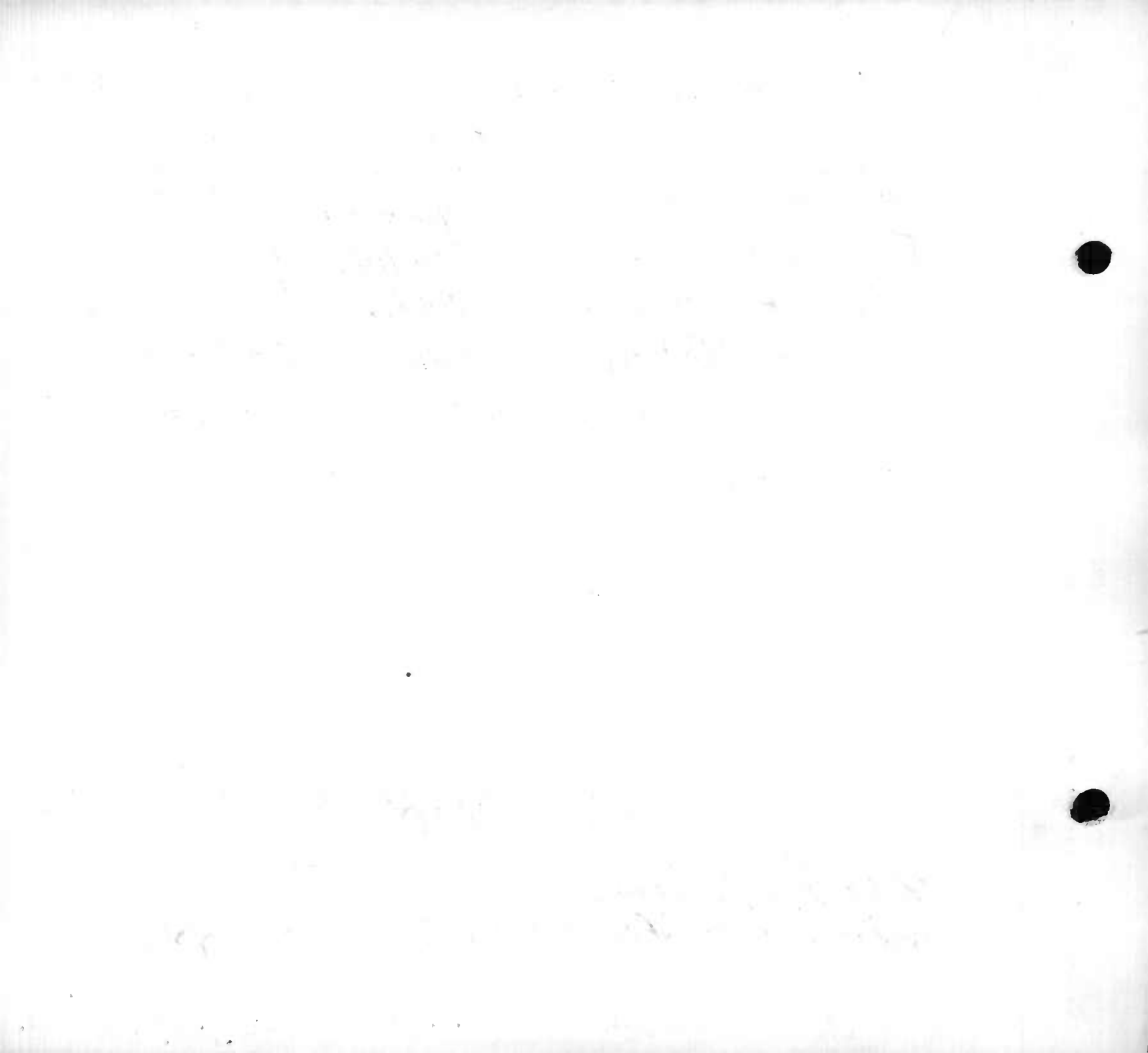
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 3471		70 3471		70 3471	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JONES, C. THOMAS		3 / 31 / 1970 9:05' A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
42 SINAI HOSPITAL OF BALTIMORE		MARYLAND.		2788	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3602 HAYWOOD AVE.		21215	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/2/91	78	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Milk Inspector		Milk Business		VA Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas S. Jones		Susan Dameron		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		214-01-8357A		Mrs. Arelia Seim 3602 Hayward Ave. 21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CEREBROVASCULAR INSUFFICIENCY.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		ATHEROSCLEROTIC CARDIOVASC. DISEASE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
1 Month ( ) Day ( ) Year ( )		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 3/30 1970 to 3/31 1970 that (I) (we) last saw the deceased alive on 3/31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		M.D.		3/31/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ANDREAS A. PETSAK MD		SINAI HOSPITAL OF BALTIMORE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		April 3, 70		Lorraine Park Cemetery	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 2 1970		Robert E. Fisher, MD		Loring Byers Funeral Directors	
				8728 Liberty Road 21133	

3602 Hayward Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-560 70 3472		BALTIMORE CITY HEALTH DEPARTMENT		70 3472	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN M. CONNOR</b>		2. DATE AND HOUR OF DEATH <b>4/1/70 6:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEM. HOSP</b>		E. STREET AND NUMBER <b>3700 E DOR RD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/93</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH E. SHEA</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. CONNOR</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-282-0932</b>		17. INFORMANT <b>J. PAUL SHEA</b>	
18. <b>485 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>BRONC. PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21234</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY Yes or No? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/27/70</b> to <b>4/1/70</b> that (I) (we) last saw the deceased alive on <b>4/1/70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ARREVEY B. SHEA MD</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ARREVEY B. SHEA MD</b>	
23D. ADDRESS <b>UNION MEM. HOSP.</b>		23E. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
24D. LOCATION <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. ADDRESS <b>4905 York Rd. Balto., Md. 212</b>			



B-400		70 3473		BALTIMORE CITY HEALTH DEPARTMENT		X	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3473			
1. NAME OF DECEASED (Type or Print) <b>HELEN Louise BEALL</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 25 70 8:00 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 25, 1970 8:00 a.m.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Dorchester</b>				6. SEX <b>F</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>10/7/1930</b> 10. AGE (In years last birthday) <b>39</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF <b>U.S.A.</b> 13. FATHER'S NAME <b>John Emory Payne</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Keeper</b> 14B. KIND OF BUSINESS OR INDUSTRY <b>O.W. Corkran &amp; Co.</b>				15. MOTHER'S MAIDEN NAME <b>Helen Phillips</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>Clifford Beall - Federalburg, Md</b>			
19. <b>4309 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) <b>ruptured berry aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Gunshot wound of head</b>							
20A. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Isidore Mihalakis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Isidore Mihalakis</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3/27/70</b>			
24C. NAME OF CEMETERY or CREMATORY <b>East New Market Md</b>				24D. LOCATION (City, town, or county) (State) <b>East New Market, Dor. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			
				25C. FUNERAL DIRECTOR <b>Smith S. Milbray</b> ADDRESS <b>East New Market</b>			

Letter from M.E.'s office

6-15-70

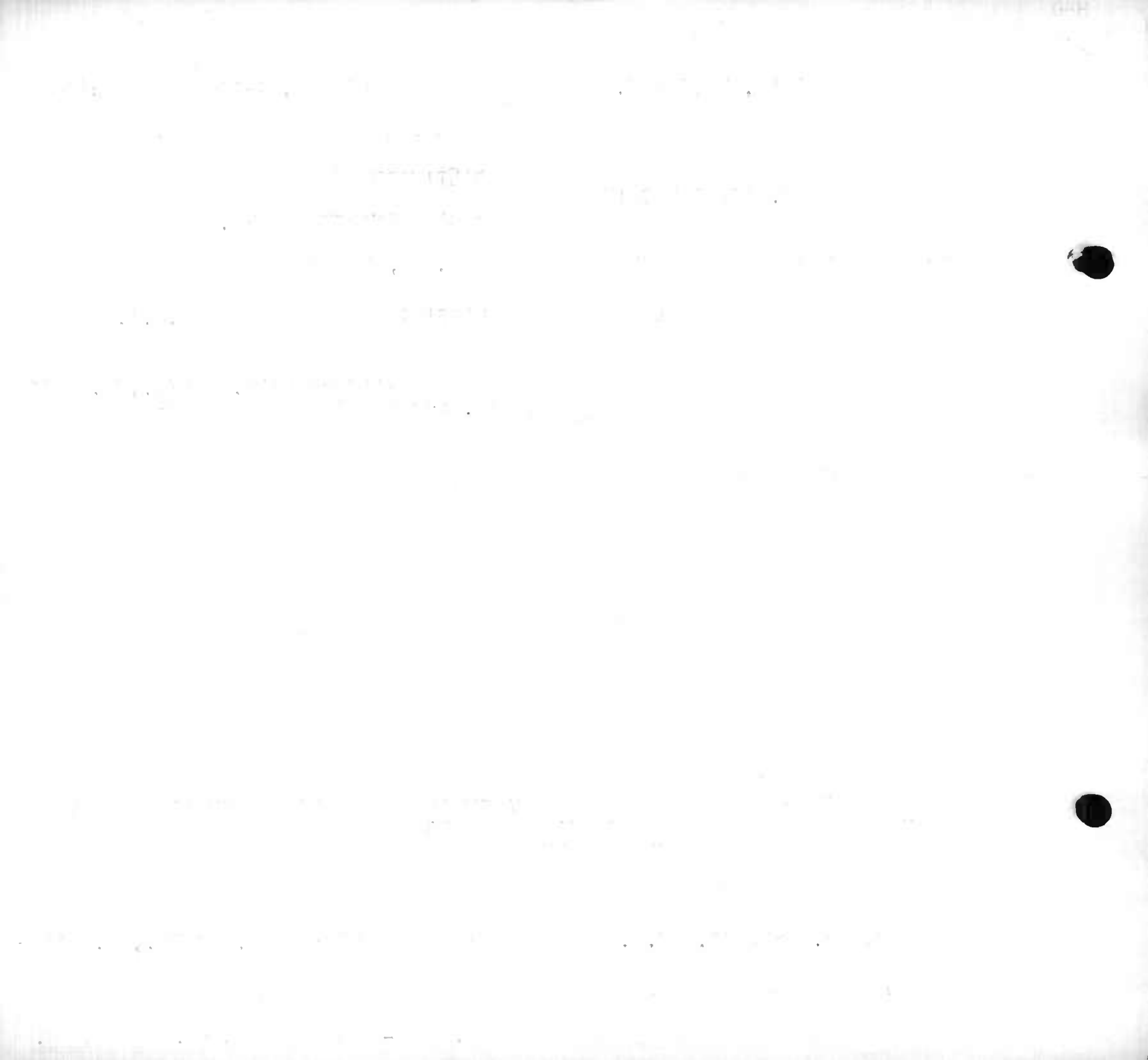
M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

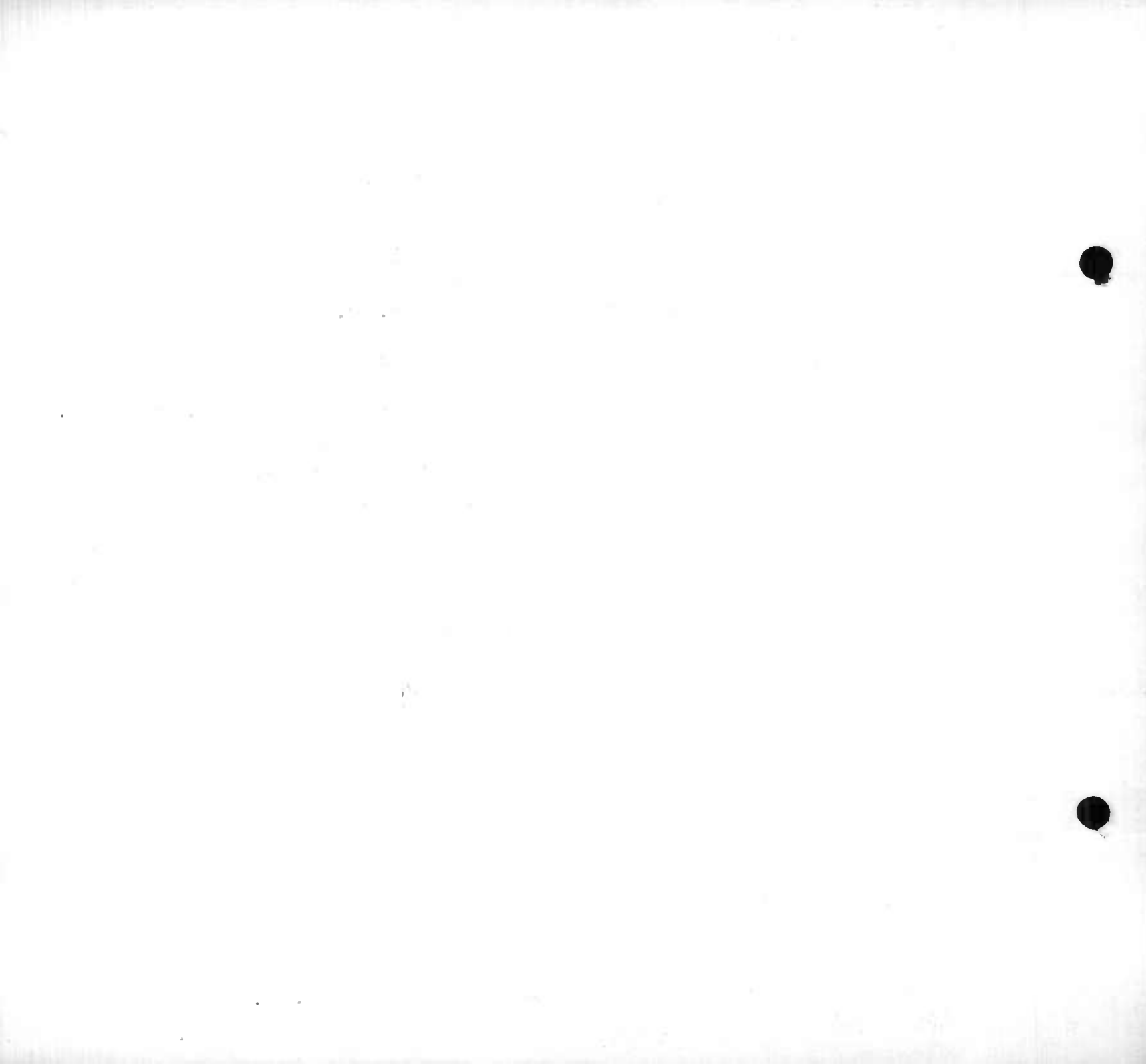
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3474</u>	
1-200 70 3474		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LEWIS, WALTER G.</u>		MARCH 31, 1970 1:42AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u>		A. STATE <u>MARYLAND</u> 21230 2582	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2704 WASHINGTON BLVD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1883</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinst</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Metal</u>	9. AGE (in years last birthday) <u>86</u>
13. FATHER'S NAME <u>Raymond Lewis</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>217-01-6910</u>		14. MOTHER'S MAIDEN NAME <u>? Scott</u>	
17. INFORMANT <u>WILKENS AVES. BALTO., MD. 21229</u>		ST. AGNES HOSPITAL RECORDS-CATON &	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 19</u> 19 <u>70</u> to <u>MARCH 31</u> 19 <u>70</u> that <input type="checkbox"/> (we) last saw the deceased alive on <u>MARCH 31</u> 19 <u>70</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Haven N. Wall Jr., M.D.</u>		23B. DATE SIGNED <u>3/31/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>HAVEN N. WALL JR. M.D.</u>		23D. ADDRESS <u>CATON &amp; WILKENS AVES. BALTO., MD. 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-3-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook &amp; Brooks Towson, Inc. Towson, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>K-522 70 3475</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3475</u>	
1. NAME OF DECEASED (Type or Print) <u>Victoria M. Kunkowski</u>				2. DATE AND HOUR OF DEATH <u>3/31/70 1:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>11 30 1903</u>		9. AGE (In years last birthday) <u>66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
13. FATHER'S NAME <u>John Markiewicz</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Raticzak</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Kunkowski</u>	
18. <u>4-5-1-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>pulmonary edema</u> (A) IMMEDIATE CAUSE <u>pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>thrombophlebitis</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Rheumatic heart disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>4 wks</u> <u>Yrs.</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>70</u> to <u>3/31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>3/31/70</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Balto. Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Mc Cully</u>				25D. ADDRESS <u>130 E. Fort Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

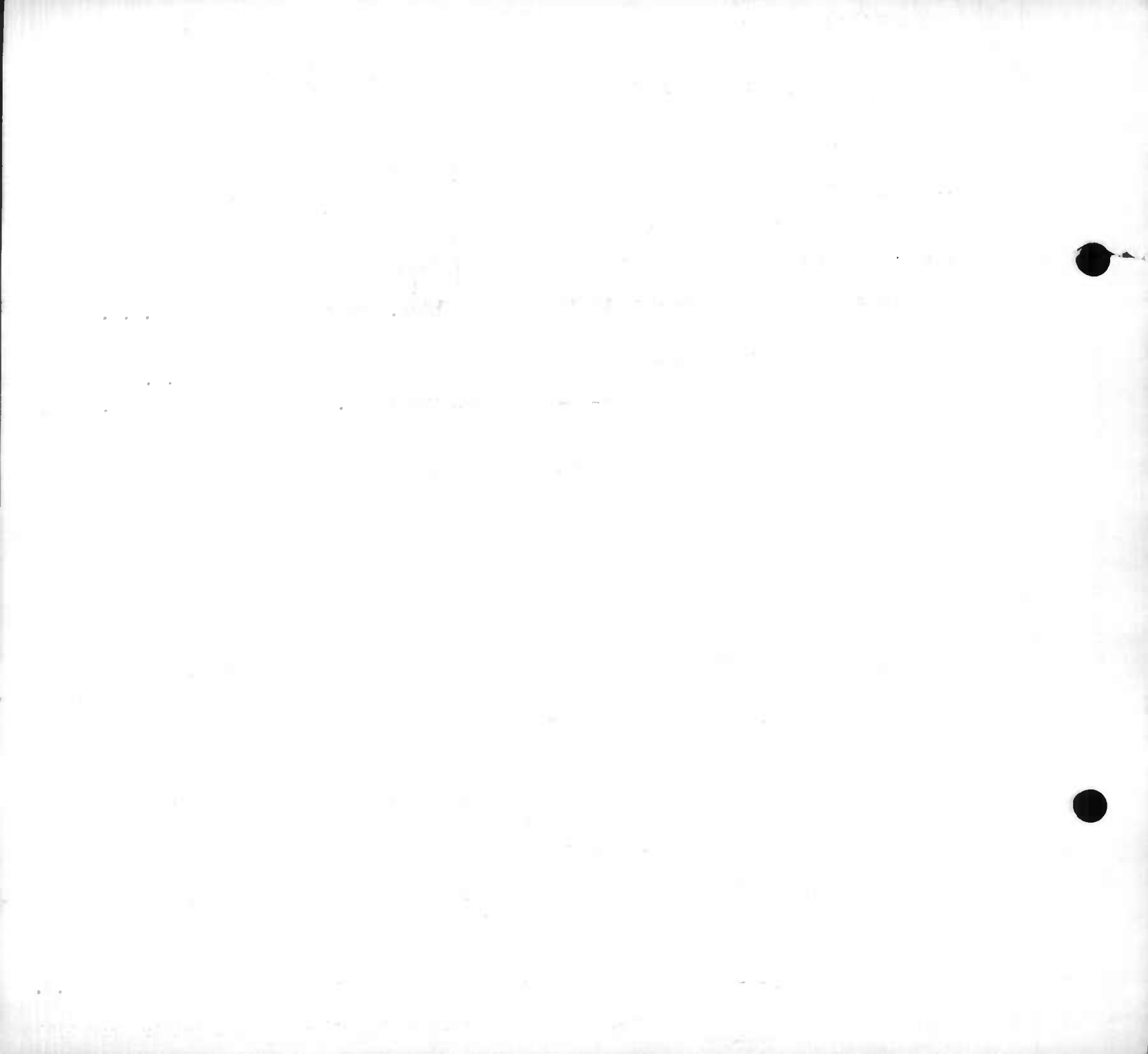
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
P-125 70 3476				70 3476			
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PIPKIN NORMAN L.</b>				2. DATE AND HOUR OF DEATH <b>4-1-70 14:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2582</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH BALTIMORE GENERAL Hospital 3001 S. Hanover St. Baltimore Maryland</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9-1-14</b>		9. AGE (In years last birthday) <b>55</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>WILLIAM KOLENBECK</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>			
16. SOCIAL SECURITY NO. <b>214 16 5763</b>				17. INFORMANT ADDRESS <b>HELEMA PIPKIN 1115 RIVERSIDE AVE.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bleeding Esophageal varices</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Liver Cirrhosis</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>3-27-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-25-70</b> 19 to <b>4-1</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>4-1-70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jose B. Corvera, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-1-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE B. CORVERA</b>				23D. ADDRESS <b>SOUTH BALTIMORE GENERAL Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4-6-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McCully</b>		ADDRESS <b>130E Fort Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320		70 3477		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		70 3477	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>WOODS, EDWARD</b>					
2. DATE AND HOUR OF DEATH <b>7/30/70</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI HOSPITAL 7 BALTIMORE</b>					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>New Jersey</b> B. COUNTY <b>V-27</b>				5. SEX <b>MALE</b>				6. RACE <b>Cauc.</b>	
C. CITY OR TOWN <b>OAKLYN</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>6/30/17</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				9. AGE (In years last birthday) <b>52</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	
E. STREET AND NUMBER <b>22 HARDING AVENUE</b>				11. BIRTHPLACE (State or foreign country) <b>Phila. Penna</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Woods</b>				14. MOTHER'S MAIDEN NAME <b>Florence Snow</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>185-05-9847</b>				17. INFORMANT <b>Mrs Frances M. Woods</b>				18. CAUSE OF DEATH <b>Acute Myocardial Infarction</b>	
19. DATE OF OPERATION <b>0</b>				20. AUTOPSY? (Yes or No) <b>No</b>				21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <b>today 17h</b> 19 <b>30</b> to <b>330</b> <b>4M/30</b> 19 <b>70</b>				23. SIGNATURE <b>Michael Xenu ml</b>				24. DATE SIGNED <b>3/30/70</b>	
25. DATE REC'D BY HEALTH DEPT. <b>APR 2, 1970</b>				26. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>				27. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>	
28. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				29. DATE <b>4-2-1970</b>				30. NAME OF CEMETERY OR CREMATORY <b>Berlin Cemetery</b>	
31. LOCATION <b>Berlin</b>				32. ADDRESS <b>7401 Belair Road</b>				33. CITY, TOWN, OR COUNTY <b>N.J.</b>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-625 70 3478</span></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p><b>CERTIFICATE OF DEATH</b></p>		<p><b>REG. NO.</b> <span style="font-size: 1.5em;">70 3478</span></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MARCHANT, JOHN W.</span></p>				<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/30/70 7<sup>32</sup> AM M.</span></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>   <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">HOUSE IN THE PINES-BELVEDERE</span> </p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission)  <b>A. STATE</b> <span style="font-size: 1.2em;">MARYLAND</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">BALTO.</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">4002 Villa Nova Road</span> </p>			
<p><b>5. SEX</b> <span style="font-size: 1.2em;">Male</span></p>		<p><b>6. RACE</b> <span style="font-size: 1.2em;">White</span></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9-26-1892</span></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <span style="font-size: 1.2em;">Mechanical Contractor</span> </p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)  <span style="font-size: 1.2em;">Md.</span> </p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b>  <span style="font-size: 1.2em;">U. S. A.</span> </p>	
<p><b>13. FATHER'S NAME</b>  <span style="font-size: 1.2em;">Alexander Washington Marchant</span> </p>				<p><b>14. MOTHER'S MAIDEN NAME</b>  <span style="font-size: 1.2em;">Ada Lyon</span> </p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b>  (Yes, no or unknown) (If yes, give war or dates of service)  <span style="font-size: 1.2em;">no</span> </p>		<p><b>16. SOCIAL SECURITY NO.</b>  <span style="font-size: 1.2em;">217-32-9915</span> </p>		<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Dessie B. Marchant</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">4002 Villa Nova Rd.</span></p>			
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <span style="font-size: 1.2em;">200.0 I Metastatic Retinoblastoma cell</span>  <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sarcoma -</span>  <span style="font-size: 1.2em;">(B) DUE TO, OR AS A CONSEQUENCE OF:</span>  <span style="font-size: 1.2em;">(C) DUE TO, OR AS A CONSEQUENCE OF:</span> </p>				<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">1 1/2 years</span> </p>			
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>							
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b>  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">June 1968</span> <b>to</b> <span style="font-size: 1.2em;">March 30 1970</span>  <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">March 30 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>							
<p><b>23A. SIGNATURE</b>  <span style="font-size: 1.2em;">R. Perez-Mera</span> </p>				<p><b>23B. DATE SIGNED</b>  <span style="font-size: 1.2em;">3/30/70</span> </p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type)  <span style="font-size: 1.2em;">R. PEREZ-MERA</span> </p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>  <span style="font-size: 1.2em;">Burial</span> </p>		<p><b>24B. DATE</b>  <span style="font-size: 1.2em;">4-2-1970</span> </p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b>  <span style="font-size: 1.2em;">Loudon Park</span> </p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)  <span style="font-size: 1.2em;">Baltimore, Md.</span> </p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b>  <span style="font-size: 1.2em;">APR 2 1970</span> </p>		<p><b>25B. NAME OF REGISTRAR</b>  <span style="font-size: 1.2em;">Robert E. Barber, M.D.</span> </p>		<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">G. Howard Strong</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">3207 W. North Ave.,</span></p>			

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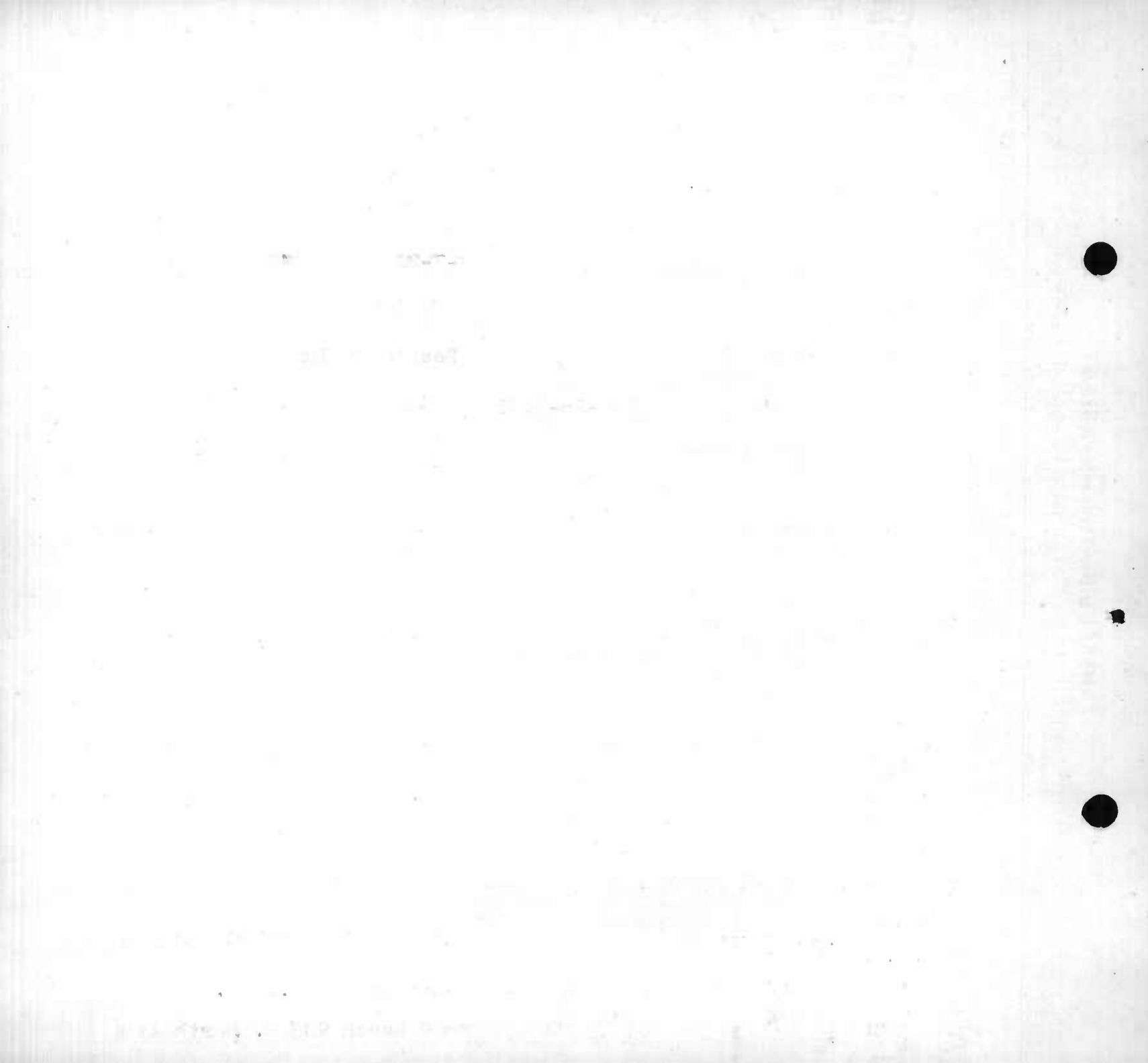
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3479	
11-200 70 3479		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Clyde MICKEY</b>			2. DATE AND HOUR OF DEATH <b>30 March 70, 10 PM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1001</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>918 Wilcox St</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-7-26</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Junk dealer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			13. FATHER'S NAME <b>Fulton Mickey</b>		
14. MOTHER'S MAIDEN NAME <b>Bessie Pullum</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1950's</b>		
16. SOCIAL SECURITY NO. <b>222-28-9491</b>			17. INFORMANT <b>Hilda Patterson, 912 Wilcox St</b>		
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc., I means the disease, injury or complication which caused death.) <b>INTRACEREBRAL BLEED</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HASCVD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>3 or more years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>29 March 1970</b> to <b>30 March 1970</b> , that (1) (we) last saw the deceased alive on <b>30 March 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. J. Rogers M.D.</b>			23B. DATE SIGNED <b>30 MAR 70.</b>		23C. PHYSICIAN'S NAME (Type) <b>W. J. Rogers MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>4/3/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cemetery Balto., Md.</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>APR 2, 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>			25C. FUNERAL DIRECTOR <b>Wm C March 928 E. North Ave</b>		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

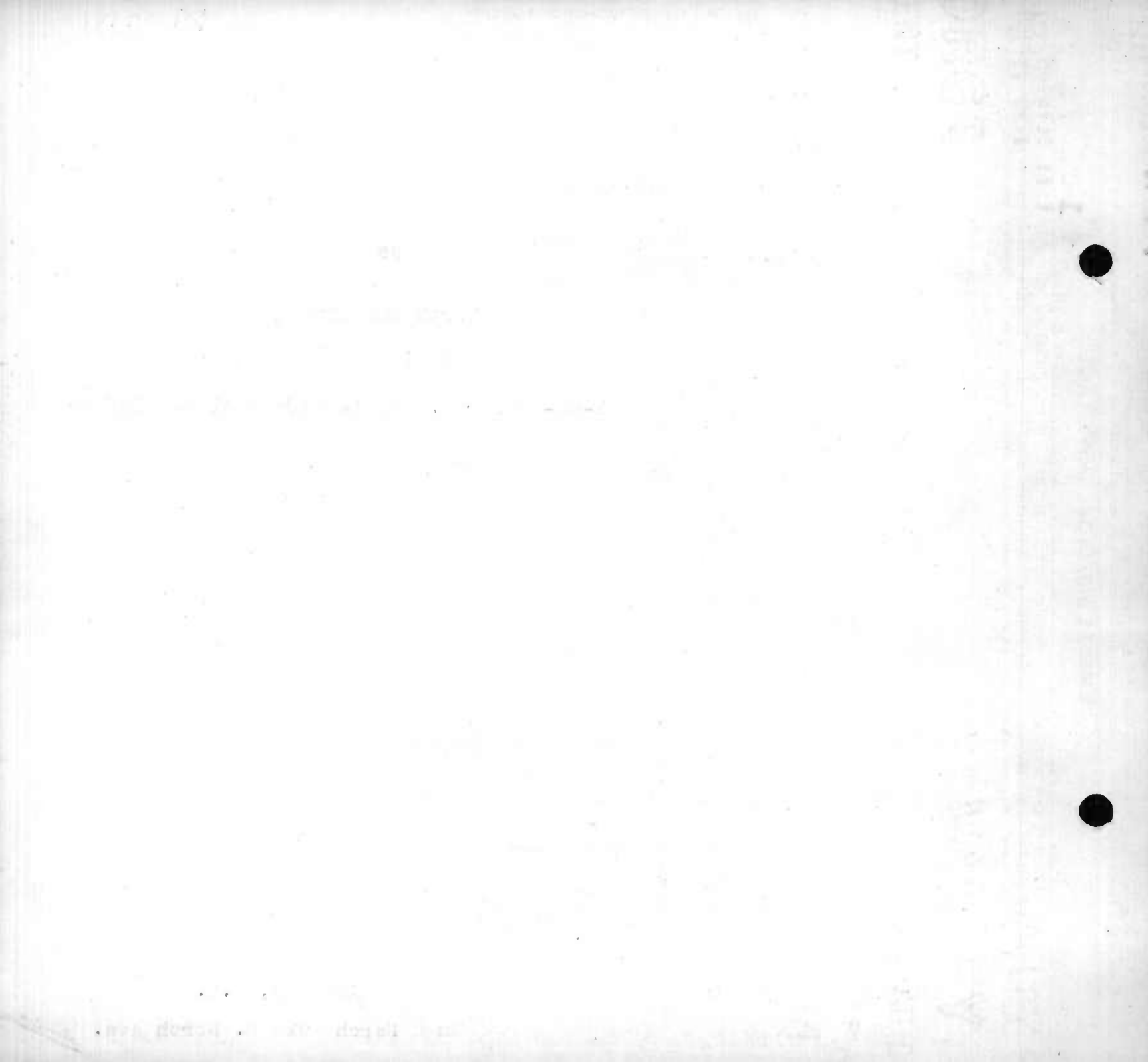
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3480</u>	
BIRTH NO. <u>W-325 70 3480</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Watkins, Ida MARIE</u>		2. DATE AND HOUR OF DEATH <u>4-1-70 1035 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2802</u>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-94</u>	
9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary DUNNWAY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-9953</u>	
17. INFORMANT <u>4940 Eastern Avenue</u>		ADDRESS <u>BCH: Records Baltimore, Maryland 21224</u>	
18. <u>436.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>CEREBRAL VASCULAR ACCID.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROTIC VAS. DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>25 yrs.</u> <u>25 yrs.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>April 1, 1970</u> to <u>April 1, 1970</u> that (1) (we) last saw the deceased alive on <u>April 1, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dele N. Schumacher M.D.</u>		23B. DATE SIGNED <u>4-1-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dele Schumacher M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/6/70</u>	
24C. NAME of CEMETERY or CREMATORY <u>ARBUTUS MEM PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>WMC. MARCH</u>		ADDRESS <u>928 E. NORTH AVE</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-400 70 3481		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3481	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CLINTON ELEY</b>		2. DATE AND HOUR OF DEATH <b>April 1 1970 12:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>806</b>		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1631 Lansing Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/96</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Lim Eley</b>		14. MOTHER'S MAIDEN NAME <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>241-62-6781</b>		17. INFORMANT <b>Mrs. Maggie Eley 1631 Lansing Ave</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 1 1970</b> to <b>April 1 1970</b> , that (I) (we) last saw the deceased alive on <b>April 1 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James E. Muller</b>		23B. DATE SIGNED <b>April 1, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>JAMES MULLER</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Ahoskie, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm C March 928 E. North Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

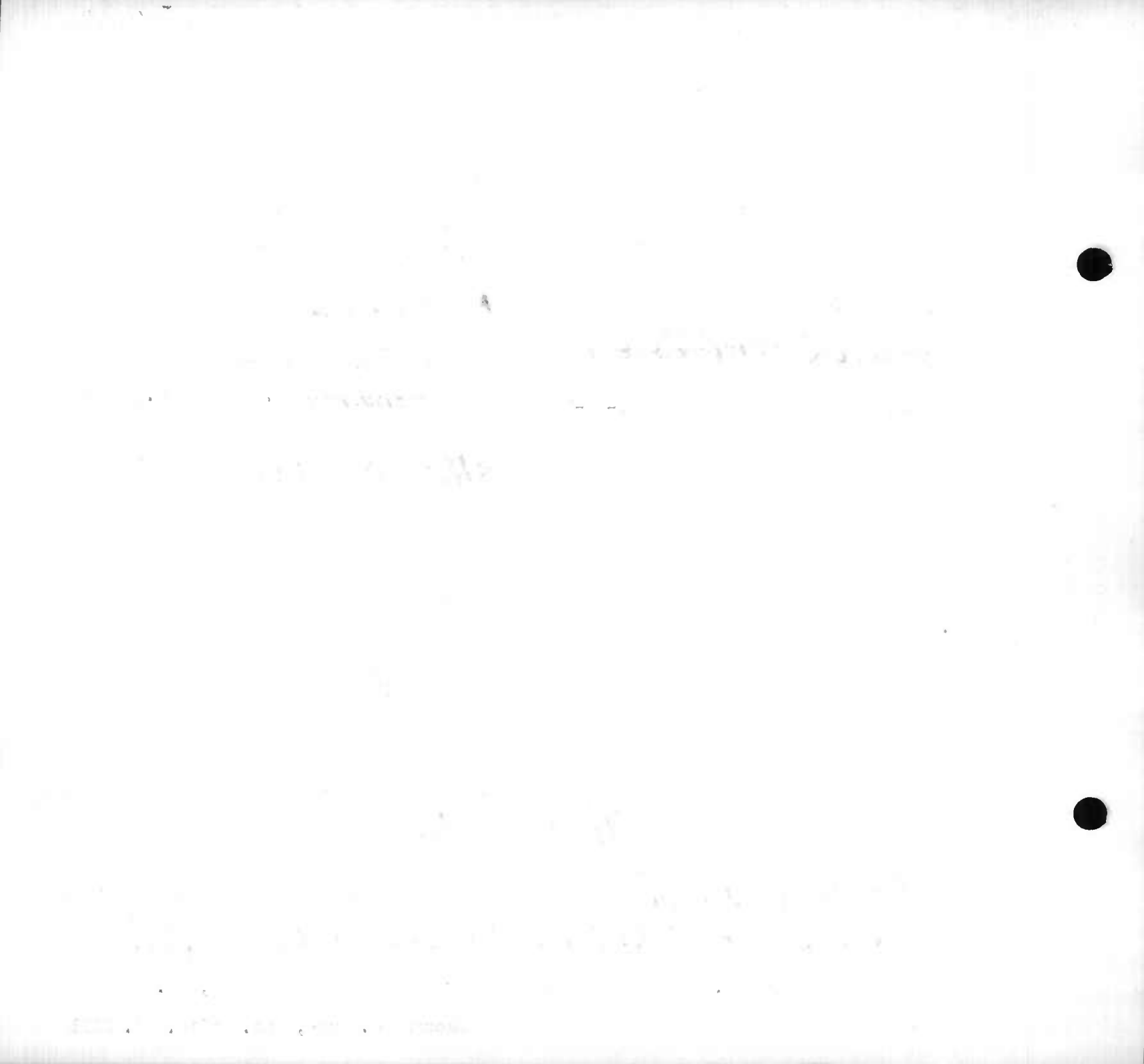
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 3482</b>
BIRTH NO. <b>70 3482</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Miss Lillie E. Albrecht</b>		2. DATE AND HOUR OF DEATH <b>3/31/1970</b> <span style="float: right;"><b>2:45 P.M.</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Jenkins Memorial Hospital</b> <b>91 1000 Caton Avenue, Baltimore, Md. 21209</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>806</b> C. CITY OR TOWN <b>Baltimore,</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Harford Garden Nursing Home 4700 Harford R.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 8, 1882</b>	9. AGE (In years lost birthday) <b>88</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Janitress Clifton Park High School</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph A. Albrecht</b>		
14. MOTHER'S MAIDEN NAME <b>Augusta Fleishmen</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-48-6076</b>		17. INFORMANT <b>Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Md.</b>		
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Anteroseptotic coronary artery disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>bronchopneumonia, chronic</b>				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>1 March 1970</b> to <b>31 March 1970</b> , that (I) (we) last saw the deceased alive on <b>31 March 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Laurence R. Gallagher, M.D.</b>		23B. DATE SIGNED <b>31 March 70</b>		23C. PHYSICIAN'S NAME (Type) <b>LAURENCE R. GALLAGHER, M.D.</b>
23D. ADDRESS <b>ST AGNES Hosp, BALTO, MD.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>4/2/70.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>

1710 N Washington St.  
Former address, called  
F.H. CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3483</u>
BIRTH NO. <u>70 3483</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ANNA R. LYNCH</u>		2. DATE AND HOUR OF DEATH <u>4/1/70</u> <u>5:00A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEM HOSP</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTO. MD.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4608 PARKWOOD AVE</u>		
5. SEX <u>R</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/02</u>	9. AGE (In years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWK</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>John Stefan</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-26-2797</u>		17. INFORMANT <u>Mr. William J. Lynch</u> ADDRESS (Same)
18. <u>H10.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>HASCVD, MI.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>R</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3/31/70</u> to <u>4/1/70</u> that (I) (we) last saw the deceased alive on <u>4/1/70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Harvey B. Sherma</u>				23B. DATE SIGNED <u>4/1/70</u>
23C. PHYSICIAN'S NAME (Type) <u>HARVEY B. SHERMA</u>		23D. ADDRESS <u>UNION MEM. HOSP</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/4/70.</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



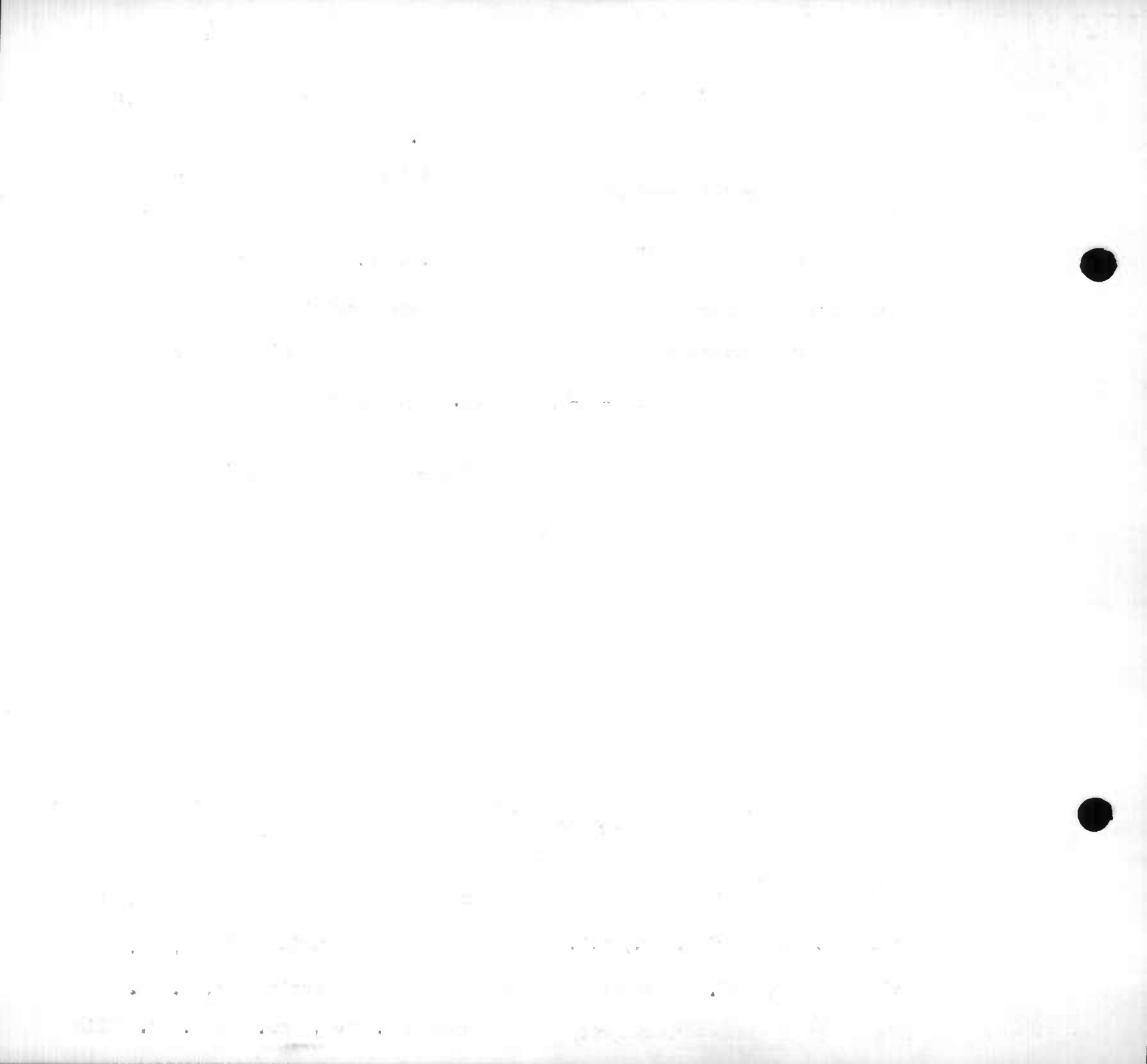
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3484

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 3484

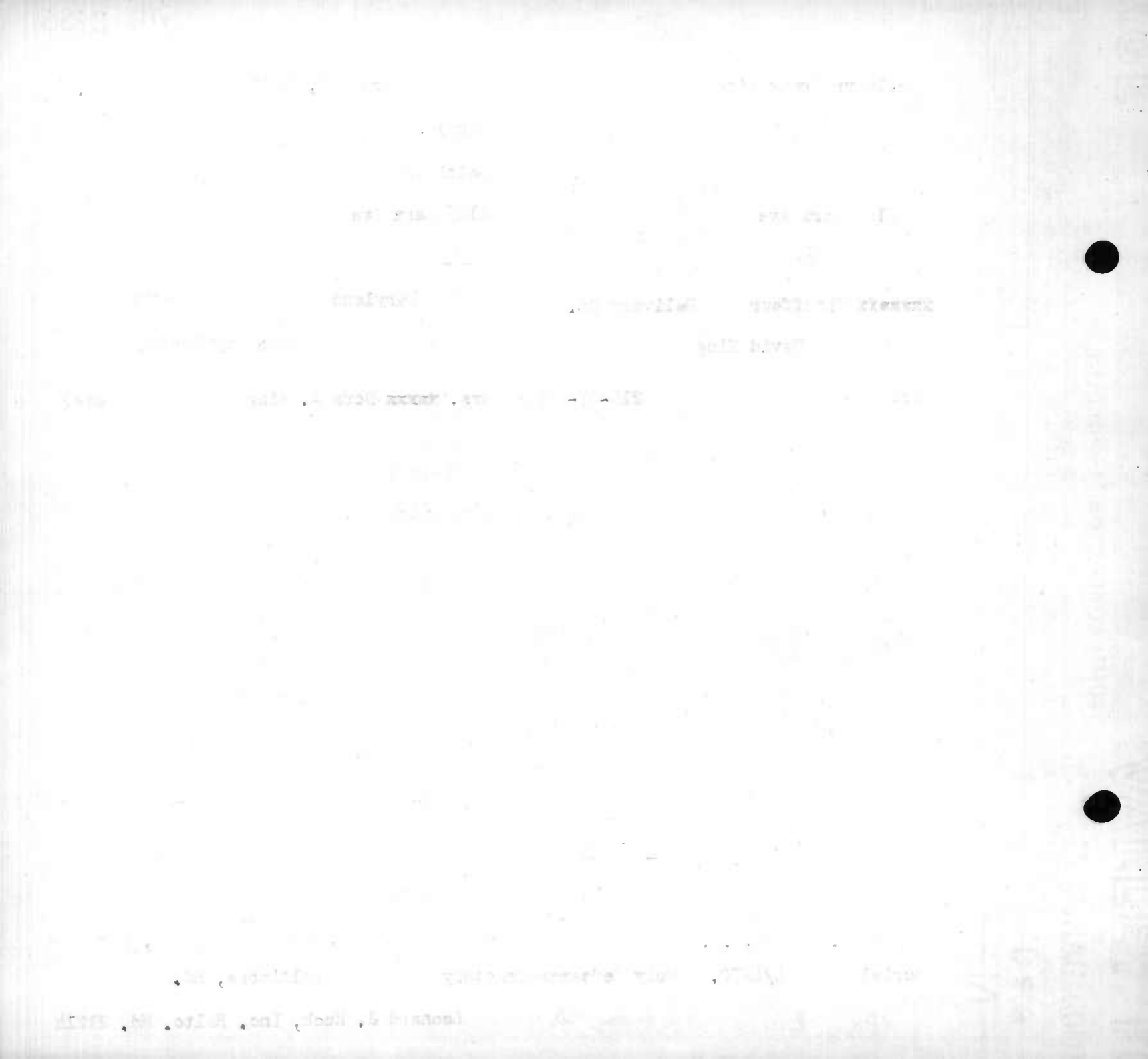
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles P. Newbraugh		March 31, 1970 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
44 Union Memorial Hospital			Md. 2749		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
June 28, 1902.			67		Retired Sales Engineer
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME
West Virginia			USA		Edward Newbraugh
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Daisy Bohrer			No		
16. SOCIAL SECURITY NO.			17. INFORMANT		
214-10-5956			Mrs. Ruth Newbraugh		
18. CAUSE OF DEATH			ADDRESS (Same)		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Gram - Negative Septicemia		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Pneumonia		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Complete Hemiplegia		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) <del>(the deceased)</del> attended the deceased from Year 1952 to March 31 1970					
that (I) <del>(the deceased)</del> last saw the deceased alive on March 31 1970 and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(the deceased)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Crawford N. Kirkpatrick, Jr., M.D.			April 1, 1970		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Crawford N. Kirkpatrick, Jr., M.D.			6 East Eager Street - Baltimore, Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/3/70.		Rosedale Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Martinsburg, W. Va.		APR 3 1970			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Faerber, R.D.		Leonard J. Ruck, Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 3485</span>
BIRTH NO. <span style="font-size: 1.5em;">70 3485</span>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Milburn Frank King</b>		2. DATE AND HOUR OF DEATH <b>March 31, 1970</b> <span style="float: right;">1:30P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>4105 Marx Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2741</b>		
5. SEX <b>Male</b> 6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Delivery Co.</b>		8. DATE OF BIRTH <b>10-8-1904</b> 9. AGE (In years last birthday) <b>65</b>
13. FATHER'S NAME <b>David King</b>		14. MOTHER'S MAIDEN NAME <b>Emma May Bordel</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-2699A</b>		17. INFORMANT <b>Mrs. <del>Nora</del> Nora A. King</b> ADDRESS <b>(Same)</b>
18. <b>492 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Obstructive Lung</b> <b>Pulmonary Emphysema</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Anemia</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>2-12-19-70</b> to <b>3-21-19-70</b> , that (I) (we) last saw the deceased alive on <b>3-21-19-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Manuel A. Gongon, M.D.</i>		23B. DATE SIGNED <b>3-31-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Manuel A. Gongon, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/4/70.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>
24D. LOCATION <b>Baltimore, Md.</b>		24E. ADDRESS <b>5002 Frankford Avenue Baltimore, Maryland</b>		

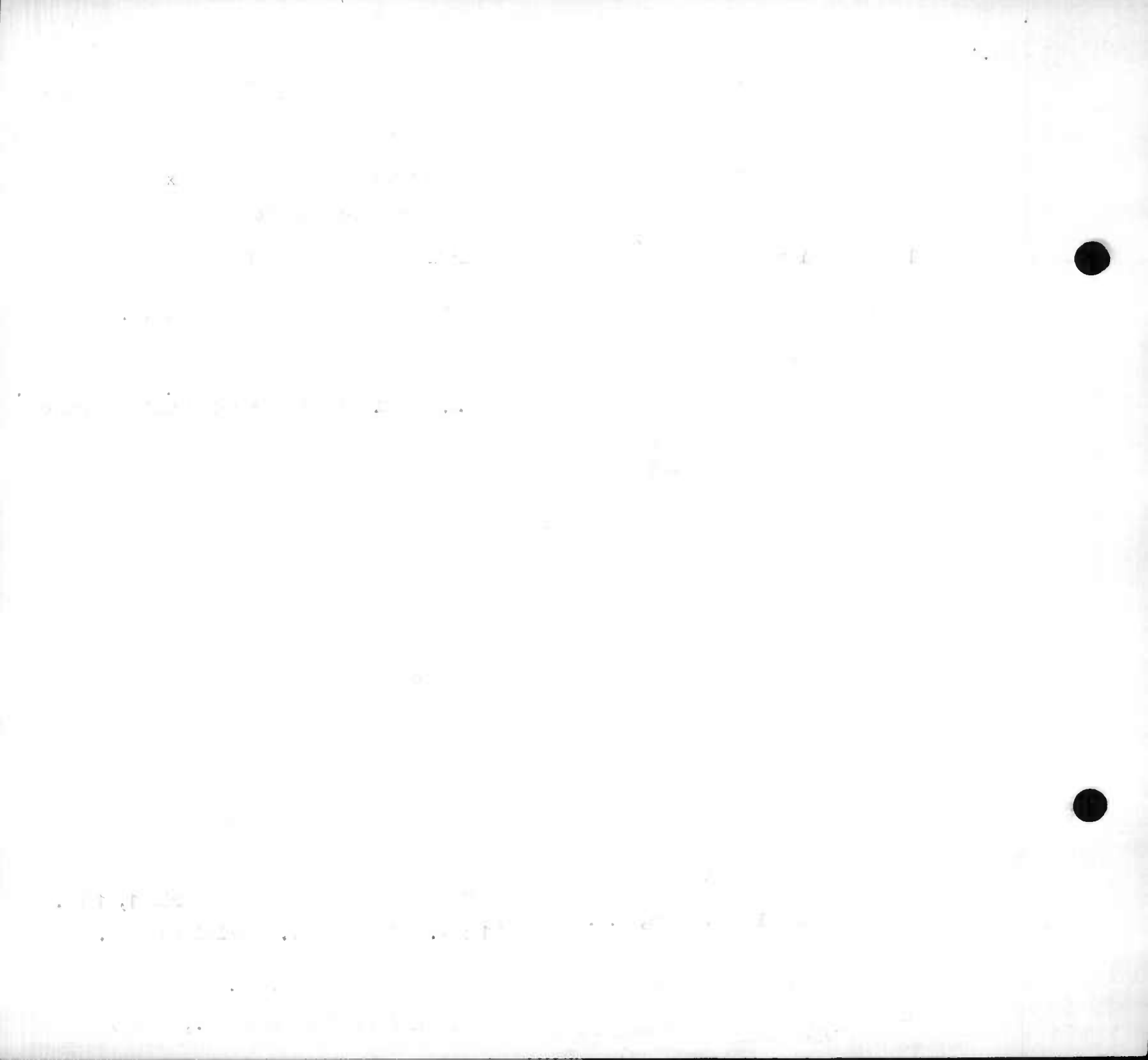




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 3486				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3486	
1. NAME OF DECEASED (Type or Print) <b>Emil G. Kraushofer</b>				2. DATE AND HOUR OF DEATH <b>March 31, 1970 3:10 P.M. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>--</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>919 Brunswick Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-98</b>		9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Kraushofer</b>				14. MOTHER'S MAIDEN NAME <b>Marie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Emil G. Kraushofer</b> ADDRESS <b>919 S. Brunswick St.</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. <b>Arterial Sclerosis</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 67</b> to <b>19 67</b> and that (I) (we) last saw the deceased alive on <b>19 67</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles A. Cahn, M.D.</b>						23B. DATE SIGNED <b>April 1, 1970.</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles A. Cahn, M.D.</b>		23D. ADDRESS <b>2145 W. Baltimore St. Baltimore Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave.,</b>		ADDRESS <b>21229</b>	

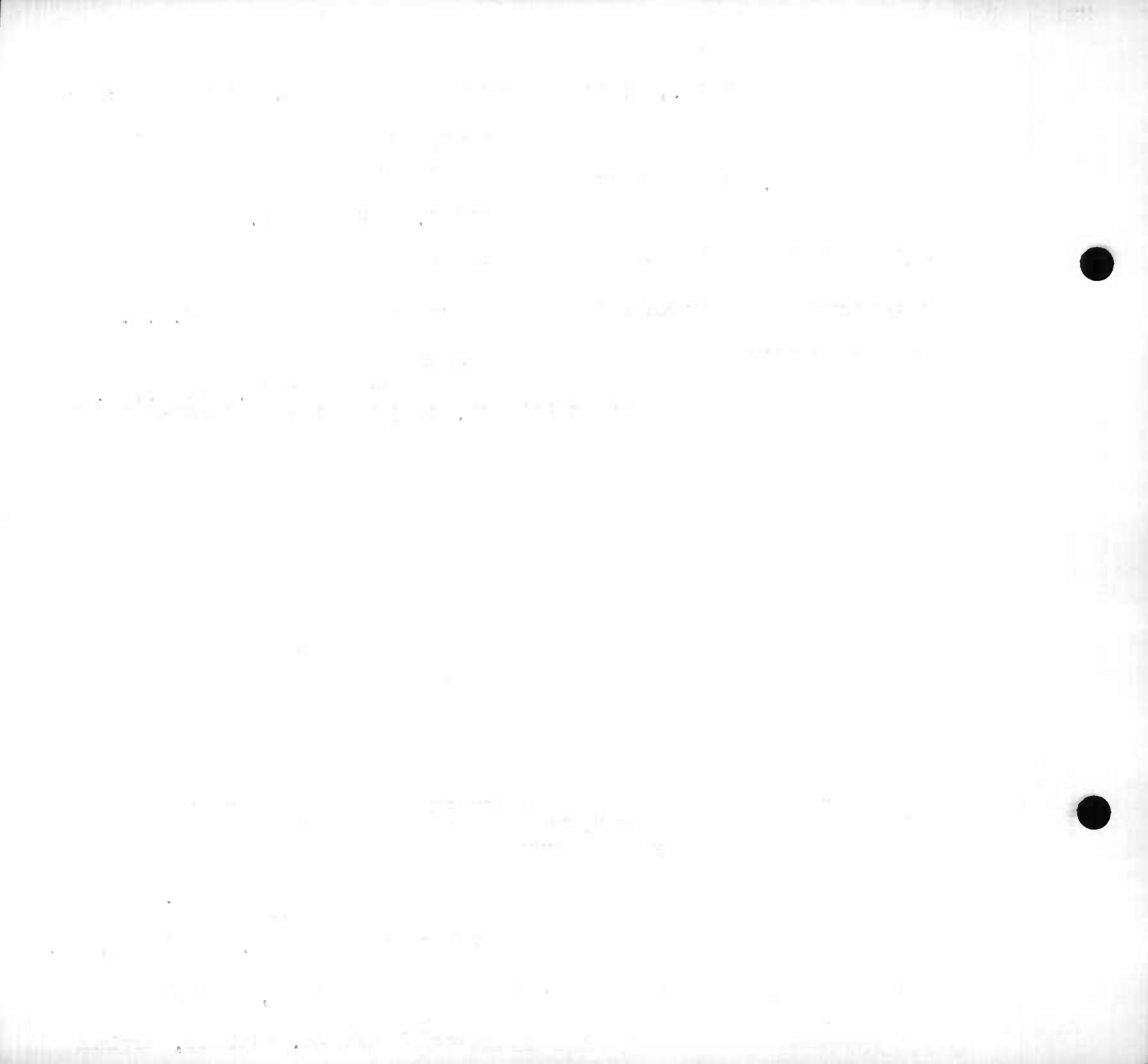


HBD  
0-622

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 3487		70 3487		70 3487	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ORZECH SR., WILLIAM HERMAN		MARCH 31, 1970		1:30AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
ST. AGNES HOSPITAL		MARYLAND		21224 2605	
40		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
12 23 99		70		MILLWRIGHT	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
MARYLAND		U.S.A.		AUTOMOBILE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
EMMANUEL ORZECH		Augusta		NO	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
213 10 4348		WILKENS AVES. BALTO., MD. 21229		ST. AGNES HOSPITAL RECORDS-CATON &	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Intracerebral Hemorrhage	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes ASCVD			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MARCH 30 19 70 to MARCH 31 19 70 that (X) (we) last saw the deceased alive on MARCH 31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Ching Hui Tsai, M.D.		3/31/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Ching Hui Tsai, M.D.		21229 CATON & WILKENS AVES. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/2/70		Gardens of Faith	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 3 1970		Robert E. Faber, M.D.		Leonard J. Ruck Inc. Baltimore, Maryland	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

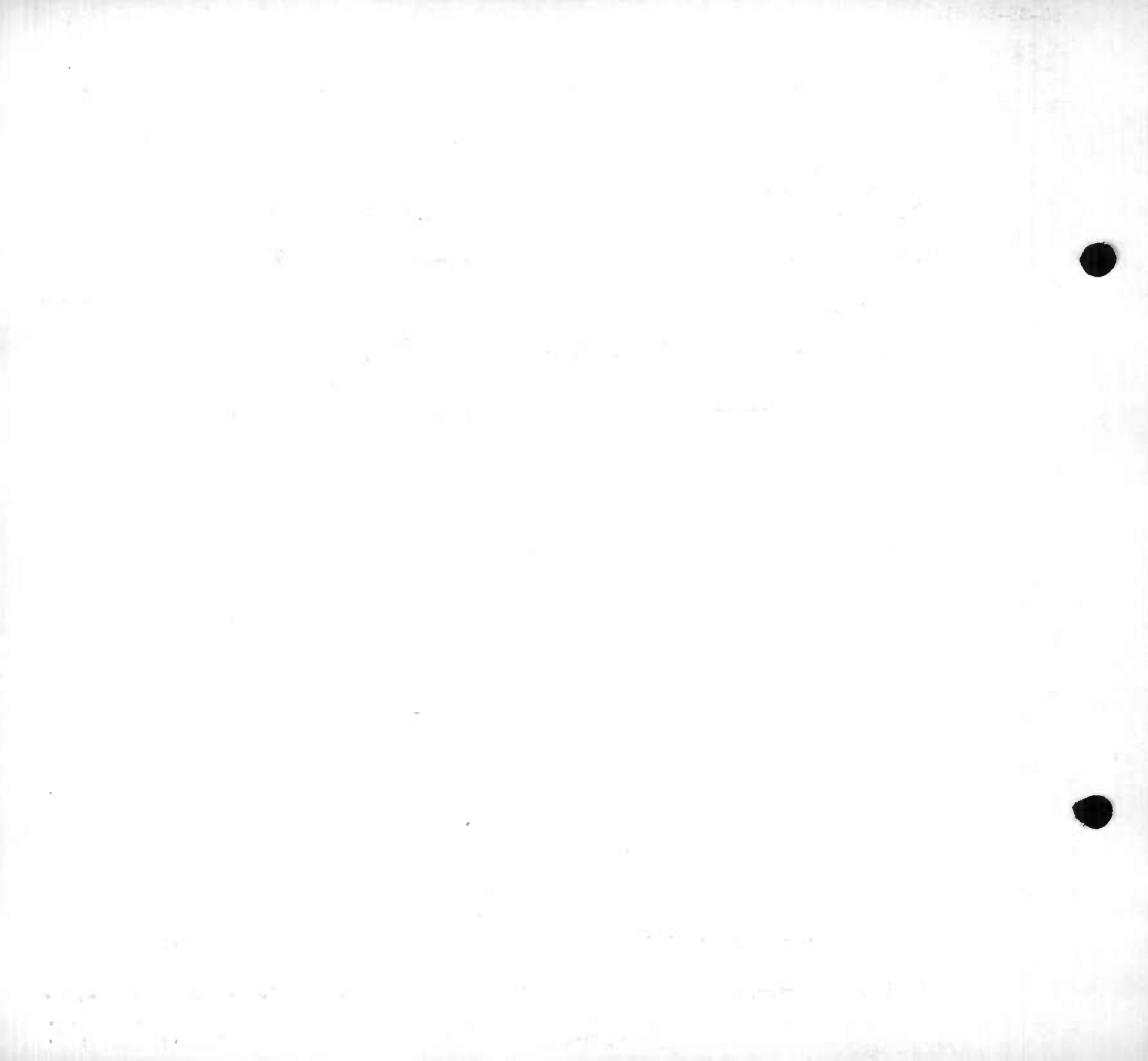
BALTIMORE CITY HEALTH DEPARTMENT				70 3488		CERTIFICATE OF DEATH X		REG. NO. 70 3488	
BIRTH NO.		70 3488		1. NAME OF DECEASED (Type or Print) <b>HOWARD E. ALLEY</b>		2. DATE AND HOUR OF DEATH <b>3/31/70 4:30 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GECY 49 HOSP</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/6/05</b>		9. AGE (In years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Retired Controller Inventory Auto</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>MILLARD ALLEY</b>				14. MOTHER'S MAIDEN NAME <b>RACKE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-9192</b>		17. INFORMANT <b>Hospital Chart</b>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>436.94 + 150.9</b>		CAUSE OF DEATH <b>Massive pulmonary embolus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>436.94 + 150.9</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular accident (clinical)</b>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>436.94 + 150.9</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>436.94 + 150.9</b>		(C) DUE TO, OR AS A CONSEQUENCE OF:							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>436.94 + 150.9</b>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pulmonary emphysema &amp; diabetes</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>70</b> to <b>3/31</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Frank V. Patricio</b>				23B. DATE SIGNED <b>3/31/70</b>					
23C. PHYSICIAN'S NAME (Type) <b>GRACIO V. PATRICIO</b>				23D. ADDRESS <b>near Charles GECY HOSP</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3489		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3489	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BUCCHERI, FLORENCE</b>		2. DATE AND HOUR OF DEATH <b>3/30/70 11<sup>00</sup> A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>815 South Tolna Street 21224</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-95</b>	9. AGE (in years last birthday) <b>74</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Howard Warthon (WARTHEN)</b>		14. MOTHER'S MAIDEN NAME <b>Isabell<sup>e</sup> Isabelle Galloway</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>	
18. <b>410.94 1250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIABETES MELLITUS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ART. SCLEROTIC CARDIOVASC. DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <b>3/27</b> 19 <b>70</b> to <b>3/30</b> 19 <b>70</b> that (H) (we) lost saw the deceased alive on <b>3/30</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dennis W. Bleakley M.D.</b>		23B. DATE SIGNED <b>3/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dennis W. Bleakley, M.D.</b>	
23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>4-2-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Kenwood Av. &amp; Trumps Mill Rd., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles L. Zeiler</b> <b>6224 Eastern Ave. Balto., 21224, Md.</b>	





C-552

BALTIMORE CITY HEALTH DEPARTMENT

70 3490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3490

BIRTH NO. 69-19445

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>FREDDY CUMMINGS Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year (noon) Estimated <input type="checkbox"/> April 1, 1970 12:00 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour (noon) April 1, 1970 12:00 M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10/23/1969</b>		10. AGE (In years last birthday) <b>5</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Freddy H. Cummings Sr.</b>		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>	
15. MOTHER'S MAIDEN NAME <b>Dorothy Laws</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. William Laws</b> ADDRESS <b>135 S. Poppleton St. 21201</b>	
19. CAUSE OF DEATH <b>036.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 2, 1970</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/4/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>John J. Bowman &amp; Son Inc.</b>		ADDRESS <b>881 Hollins St. 23, Md.</b>	



K-564

70 3491

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3491

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MATHIAS KNOERLEIN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 31 70 12:32a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>City Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 31, 1970 12:32a M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct. 9, 1909</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence F. Knoerlein</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Sheriff</b>	
15. MOTHER'S MAIDEN NAME <b>Anna M. Schneider</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>216-01-8002</b>		18. INFORMANT <b>May E. Knoerlein</b>	
19. <b>412.44250.9</b>		ADDRESS <b>Same</b>	
CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes mellitus</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D. Deputy Chief Medical Examiner</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/31/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-70.</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba., Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, R.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles S. Seiler</b>		ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	

1945

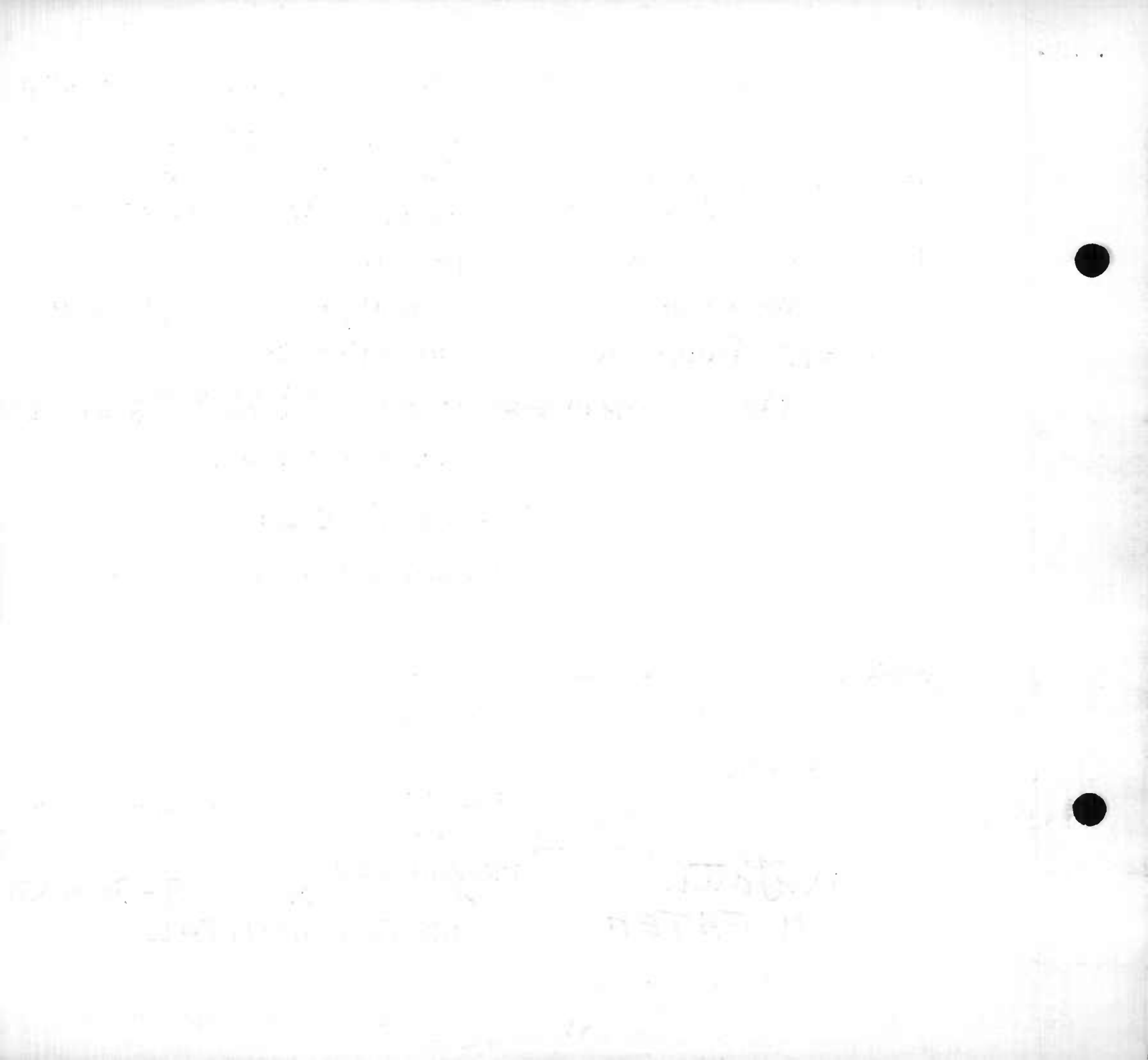
1945



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3492	
BIRTH NO. 70 3492		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LOSOVSKY MRS. FRANCES</b>		2. DATE AND HOUR OF DEATH <b>3-30-1970 2:45 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland Gen. Hospital 48 Baltimore</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Baltimore</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>6800 BRENTWOOD AVE.</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-09</b>	9. AGE (In years last birthday) <b>67</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>RUTY.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>STEVE PUVACIK</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>219 18 9420</b>		17. INFORMANT <b>The Son</b> ADDRESS <b>1903 Tolson Ave Baltimore, MD. 21222</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CEREBRAL Hemorrhage.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C.V.D.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized Arteriosclerosis</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>3-28-1970</b> to <b>3-30-1970</b> that (I) (we) last saw the deceased alive on <b>3-30-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>M. FATEH</b>		23B. DATE SIGNED <b>3-30-1970</b>		23C. PHYSICIAN'S NAME (Type) <b>M. FATEH</b>	
23D. ADDRESS <b>MD. Gen. Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-1970</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>WALTER DABROWSKI</b> ADDRESS <b>1005 DUNDALK AVENUE</b>	

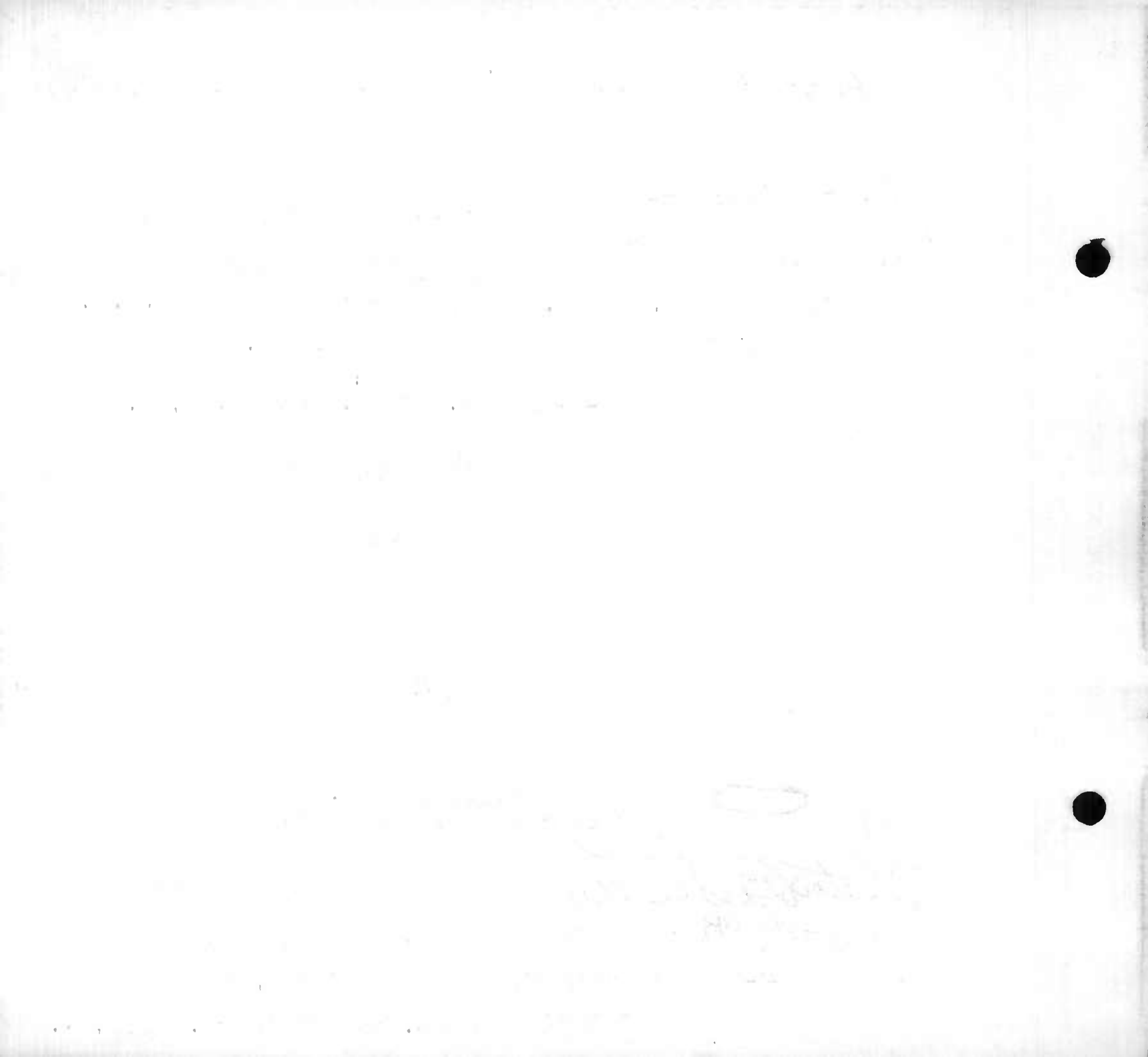




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 3493		70 3493	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALBERT WISER</b>		2. DATE AND HOUR OF DEATH <b>MAR 30, 1970 11:28 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		5. SEX <b>Male</b> 6. RACE <b>White</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>8128 DELHAVEN RD.</b>		8. DATE OF BIRTH <b>2/19/22</b>		9. AGE (In years last birthday) <b>48</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Lambert Wiser</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Plank</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>185-14-6176</b>		17. INFORMANT <b>Wife</b> <b>Mrs. Judith N. Wiser Dundalk, Md. 21222</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST <b>ASCVD.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 24</b> 19 <b>70</b> to <b>MARCH 30</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>MARCH 30</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Victor Borden MD</b>		23B. DATE SIGNED <b>3/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>VICTOR BORDEN MD</b>	
23D. ADDRESS <b>SINAI HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. DATE RECEIVED BY HEALTH DEPARTMENT <b>APR 3 1970</b>	
24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24G. FUNERAL DIRECTOR <b>John J. Duda</b>		24H. ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	





W-320

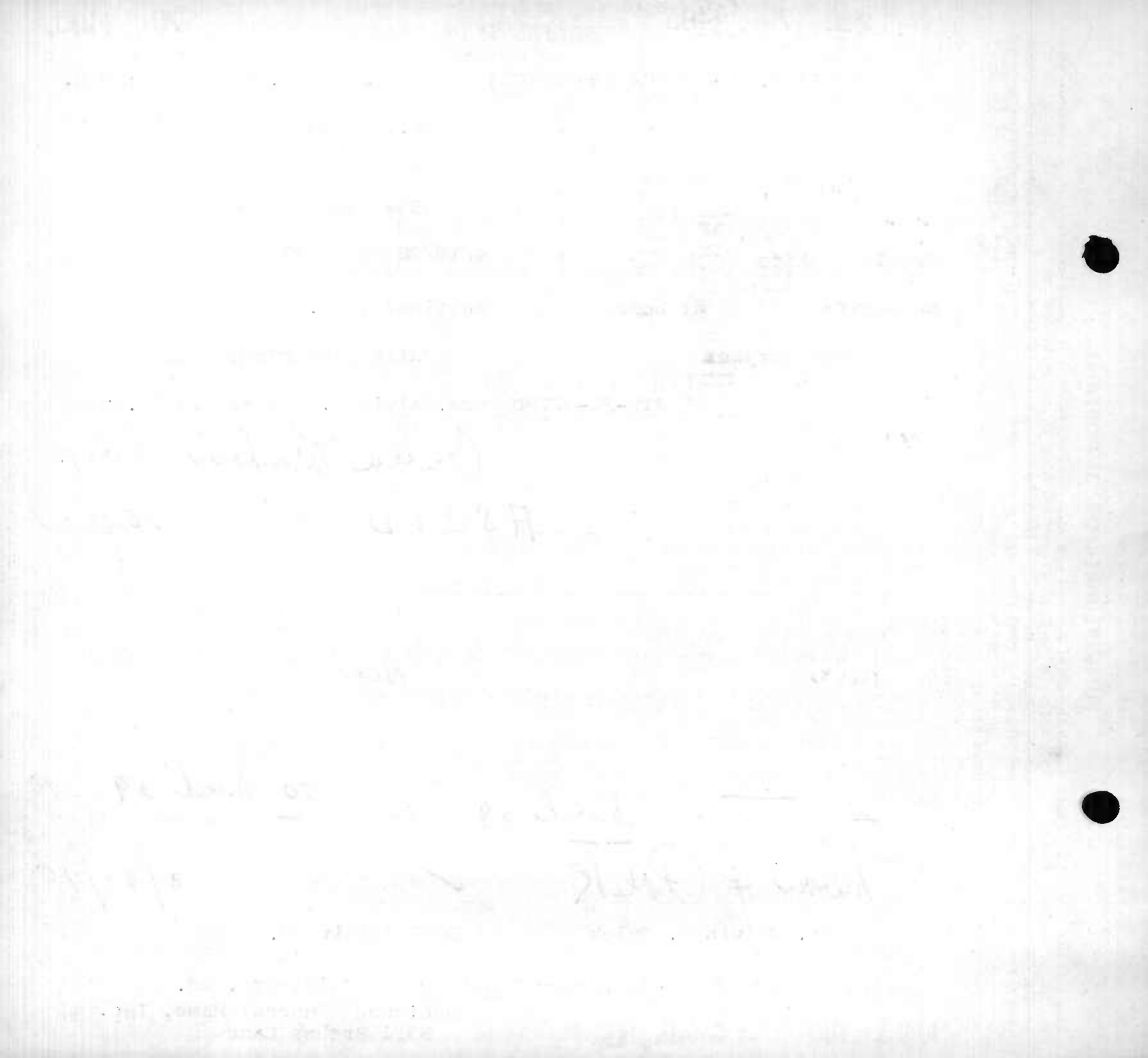
BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. <b>70 3494</b>	
BIRTH NO. <b>J.</b>							
1. NAME OF DECEASED (Type or Print) <b>PAUL WOODHOUSE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <b>3</b> , Day <b>30</b> , Year <b>70</b> Hour <b>11:09a</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				3. DATE PRONOUNCED DEAD Month <b>March</b> , Day <b>30</b> , Year <b>1970</b> Hour <b>11:09a</b> M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>							
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Lansdowne</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>10-6-1908</b>		10. AGE (in years lost birthday) <b>61</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Woodhouse</b>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Maker Retired</b>			
15. MOTHER'S MAIDEN NAME <b>Rosa Kaiser</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>			
17. SOCIAL SECURITY NO. <b>216-03-6711</b>				18. INFORMANT ADDRESS <b>21227 Mrs. Jeannette B. Woodhouse, 409 Caledonia Ave</b>			
19. CAUSE OF DEATH							
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>E 980.1 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> </div> <div style="width: 35%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Salicylate Intoxication</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="width: 35%;"></div> </div>							
20A. DATE OF OPERATION <b>0</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
21. AUTOPSY? (Yes or No) <b>No</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Spring Grove Hospital</b>				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>3 30 70 ? m.</b>			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Unknown</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D., Deputy Chief Medical Examiner</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>4-2-1970</b>			
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>			
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>				25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-522 70 3495				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3495	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SOPHIA F. WONSOWICZ (WASOWICZ)</b>				2. DATE AND HOUR OF DEATH <b>March 29, 1970 7:20 p. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3534 Pelham Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md., 21213</b> B. COUNTY <b>2633</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3534 Pelham Avenue</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/18/92</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Waryasz</b>				14. MOTHER'S MAIDEN NAME <b>Julia Bernardzckowski</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-32-3778D</b>		17. INFORMANT ADDRESS <b>Mrs. Calvin T. Miskelly, dght. above</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>ASCVD</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>	
19. DATE OF OPERATION <b>None</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>None</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 29 19 70</b> to <b>March 29 19 70</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Melvin F. Polek</b>				23B. DATE SIGNED <b>3/31/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Melvin F. Polek</b>	
23D. ADDRESS <b>3603 Belair Rd.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>4/2/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Charles J. Brehms</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3496

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HOMER LAYNE (LANE)

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

3

29

70

1 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

701

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (in years  
last birthday)

42

# Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

912 N. Linwood Ave.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joshua Layne

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Paper Maker Chesapeake Paper Board Co.

15. MOTHER'S MAIDEN NAME

Angeline Addair

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL  
SECURITY NO.

234-42-0464

18. INFORMANT

ADDRESS

Elizabeth Friend Layne, wife, above

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/2/70

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
2601 E. Madison St.

ADDRESS

# ACADEMIC RECORD

Page 1 of 1

Student Name

Grade

Subject

Score

Comments

Signature

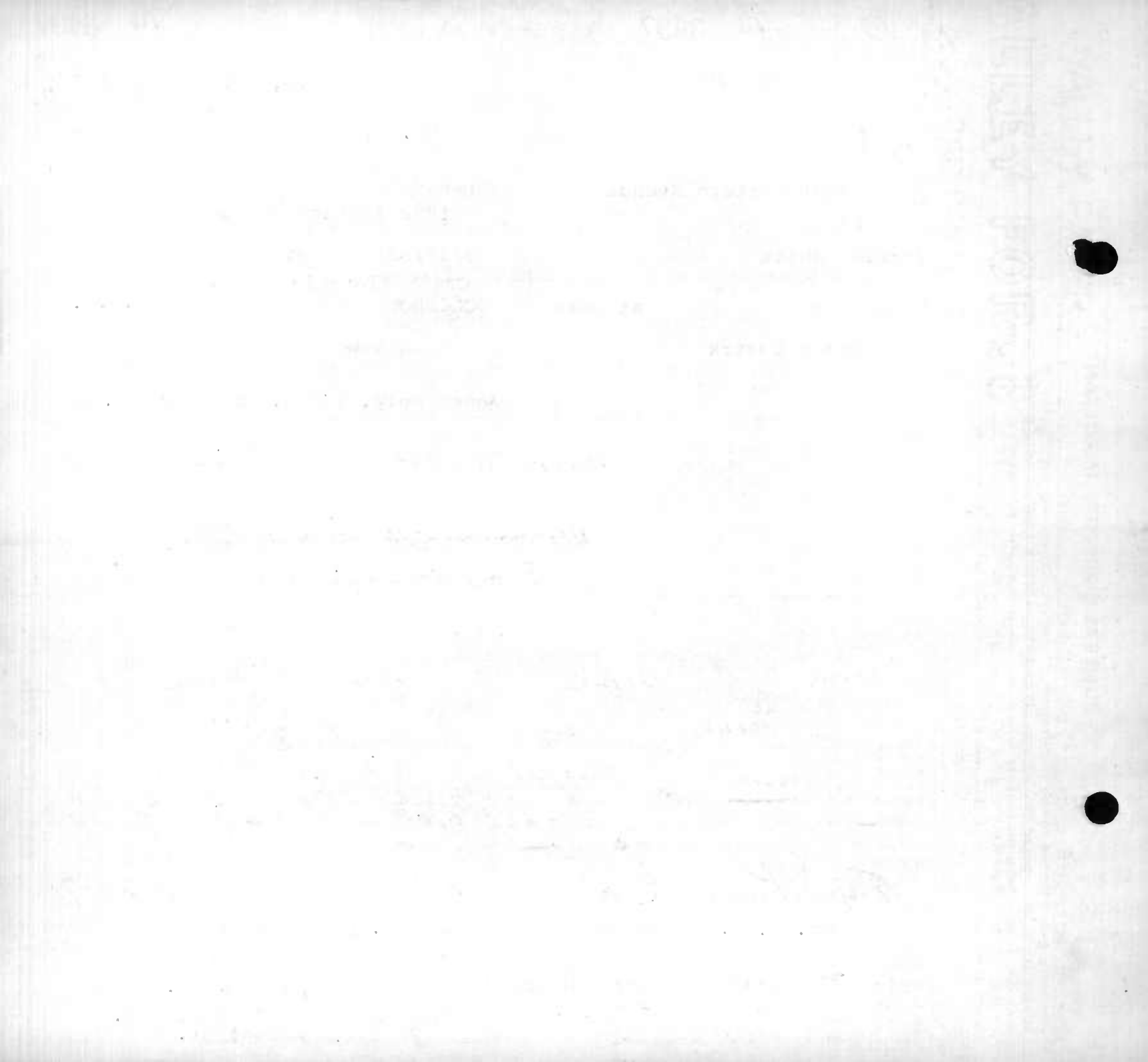
Date

Teacher



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 3497</span>	
B-450 70 3497 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>MARY BLUM</b>			2. DATE AND HOUR OF DEATH <b>March 30, 1970</b> <span style="float: right;">9:30 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1822 Eastern Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>202</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1822 Eastern Avenue</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/82</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b> <del>Chicago</del>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Peter Vysrk</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Agnes Holy, 253 S. Regester St.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL FAILURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSIVE C.V. DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIO SCLEROSIS</b> (C) <b>?</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-24-70</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>			20. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>None</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b> 19C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b> 19D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b> 19E. HOW DID INJURY OCCUR? <b>None</b>		
21. I certify that (I) (the hospital) attended the deceased from <b>JAN 26 1970</b> to <b>3-30-70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>3-28-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22. SIGNATURE <b>E. A. Schimunek M.D.</b> DEGREE <b>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></b> 23. DATE SIGNED <b>3-31-70</b>		
23. PHYSICIAN'S NAME (Type) <b>Dr. E. A. Schimunek</b>			24. ADDRESS <b>842 S. East Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/70</b>	24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1970</b>		25B. NAME OF REGISTRAR <b>Blair E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601 E. Madison St.</b>	

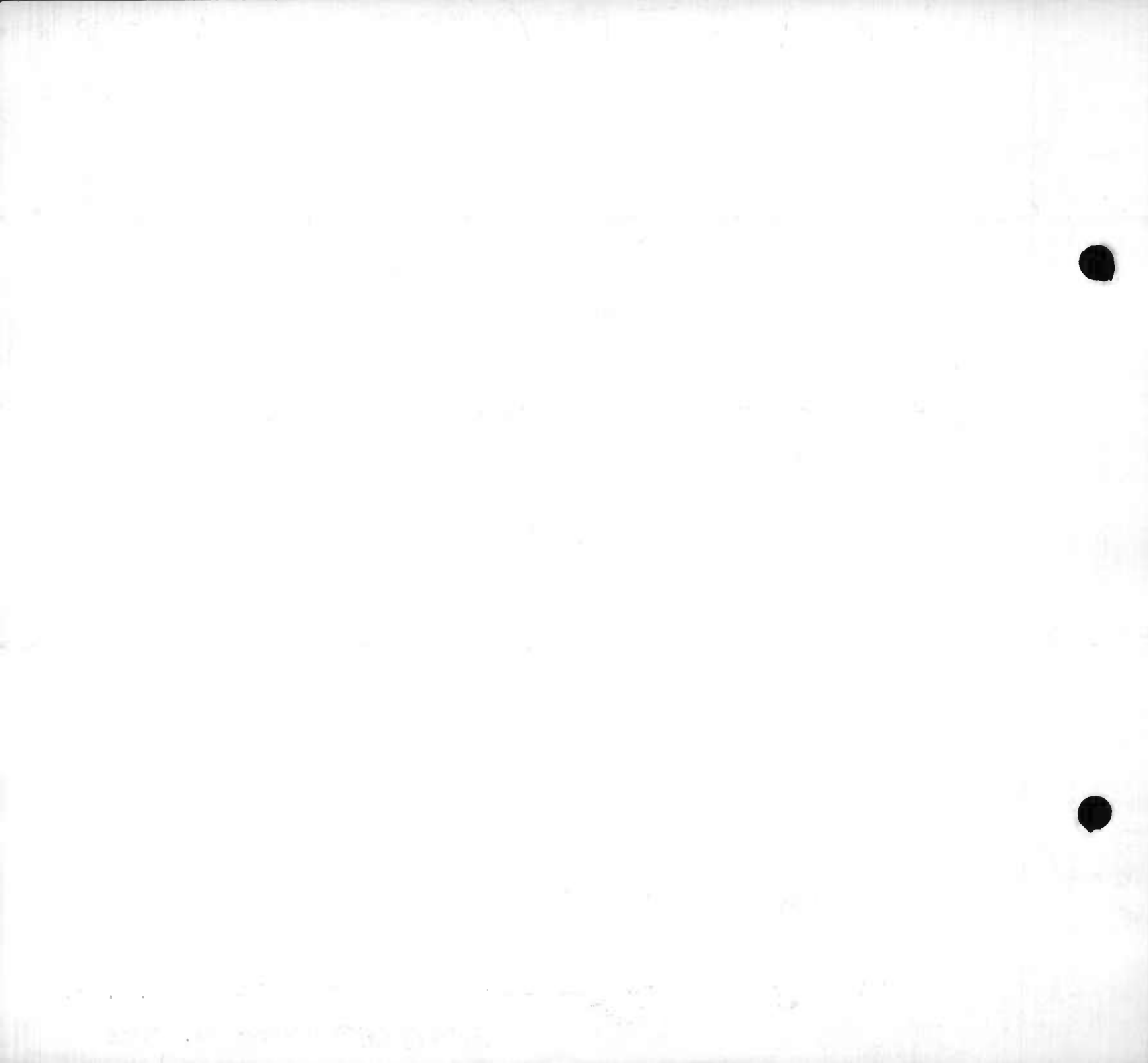




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-340		70	3498	BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <span style="font-size: 2em;">X</span>		REG. NO. <span style="font-size: 2em;">70</span> <span style="font-size: 2em;">3498</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">JOHN STEELE</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">4-1-70</span> <span style="font-size: 1.5em;">10<sup>15</sup> A M.</span>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">SOUTH BALTIMORE GEN. HOSP</span> <span style="font-size: 1.5em;">43</span>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.5em;">MD.</span> B. COUNTY <span style="font-size: 1.5em;">ANNE ARUNDEL Co.</span>		C. CITY OR TOWN <span style="font-size: 1.5em;">SEVERNA PARK</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <span style="font-size: 1.5em;">M</span>		6. RACE <span style="font-size: 1.5em;">CAUC</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">11-22-97</span>		9. AGE (in years last birthday) <span style="font-size: 1.5em;">72</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">RETIRED</span>				10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">TAVERN OWNER</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">ENGLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">UNKNW.</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">UNKNW.</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">YES</span> <span style="font-size: 1.5em;">WWI</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">216-05-5361A</span>		17. INFORMANT <span style="font-size: 1.5em;">Sadie</span>		ADDRESS <span style="font-size: 1.5em;">Same as #4</span>	
18. <span style="font-size: 1.5em;">410.9</span> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Profound Cardiovascular Collapse</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Acute Myocardial Infarction</span> (B) DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">ASCVD</span> (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.5em;">ANEMIA, etc unknown. Suspect M.I. Bleeding 2° Coumadin K.</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">MINS</span>  <span style="font-size: 1.5em;">MINS</span>  <span style="font-size: 1.5em;">YEARS</span>  <span style="font-size: 1.5em;">DAYS</span>					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">3-31</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">4-1</span> 19 <span style="font-size: 1.5em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">4-1</span> 19 <span style="font-size: 1.5em;">70</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.5em;">Donald M. Wood, MD</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">4-1-70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">DONALD M. WOOD</span> <span style="font-size: 1.5em;">MD</span>			
23D. ADDRESS <span style="font-size: 1.5em;">South Balt. Gen.</span>				24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>					
24B. DATE <span style="font-size: 1.5em;">4/6/70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Glen Haven Memorial PARK</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Glen Burnie, Md. A. A. Co.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">APR 3 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">McCully FR37</span>		ADDRESS <span style="font-size: 1.5em;">Patapsco Ave. 21225</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		70 3499	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		JAMES G. WARRICK		4/1/70		3:30 PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived if institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
BON SECOURS HOSPITAL				MD.		WESTMINSTER			
34 BALTIMORE MD.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				WESTMINSTER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER		61 W. MAIN STREET			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/27/98	71					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BREAD SALESMAN			WHOLESALE			HARTFORD CO. MD.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
THOMAS WARRICK				MARIA BARBORA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				215-05-2910A		MRS. HELEN P. WARRICK		61 W. MAIN ST. WESTMINSTER, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.3 I				Multiple Pulmonary Emboli and Myocardial Ischemia.				6 days	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Coronary atherosclerosis				12 yrs.	
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/20/70			LUMBAR DISC			No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from March 7 1970 to April 1 1970 that (I) (we) last saw the deceased alive on April 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Dionicio Garcia Jr. M.D.						4/1/70			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
DIONICIO GARCIA JR. M.D.						BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		4/4/70		WESTMINSTER CEMETERY		WESTMINSTER, MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 3 1970		Robert E. Taylor M.D.		J. S. Myers Jr.		Westminster, Md.			



**BALTIMORE CITY HEALTH DEPARTMENT**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO. 70 3500

<b>1. NAME OF DECEASED</b> (Type or Print) <p align="center"><b>THOMAS A. JOHNS</b></p>				<b>2. DATE OF DEATH</b> Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <span style="float:right">M.</span>			
<b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <p><u>31 BALTO. CITY HOSPITAL</u></p>				<b>3. DATE PRONOUNCED DEAD</b> Month Day Year Hour <p align="right"><u>March 31, 1970</u> <u>9:30 A.M.</u></p>			
<b>6. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>				<b>7. RACE</b> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/>		<b>8. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>9. DATE OF BIRTH</b> 22 Nov. 1912				<b>10. AGE</b> (In years last birthday) <u>57</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>T. DAVID JOHNS</u>			
<b>14. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter &amp; Jap.</u>				<b>15. MOTHER'S MAIDEN NAME</b> <u>LOUISE ZIMMERMAN</u>			
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				<b>17. SOCIAL SECURITY NO.</b> <u>218-07-0952</u>		<b>18. INFORMANT</b> <u>Max. ALVINA JOHNS, 223 N. Port St.</u>	
<b>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <p align="center"><u>Arteriosclerotic cardiovascular disease</u></p>				<b>CAUSE OF DEATH</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C)			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>20A. DATE OF OPERATION</b> <u>4-3-70</u>				<b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			
<b>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>22C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				<b>22D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)			
<b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				<b>22F. HOW DID INJURY OCCUR?</b>			
<b>23. I certify that I held an</b> Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> <b>and that on this basis, death in my opinion resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type): <u>Ronald N. Kornblum, M.D.</u>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
DATE SIGNED: <u>4/1/70</u>							
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>24B. DATE</b> <u>4-3-70</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>GARDENS OF FAITH</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTO. CO., MD</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>APR 3 1970</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fisher, Jr.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>ULLRICH FUNERAL HOME, BALTO., MD.</u>		<b>ADDRESS</b> <u>21406</u>	

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